

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 07702			
1 DECEASED NAME (TYPE OR PRINT) Charles Henry Akers				2a. DATE OF DEATH MONTH DAY YEAR March 2, 1980				2b. HOUR P M 1:48 P			
3 SEX Male		4 RACE Negro		5 DATE OF BIRTH MONTH DAY YEAR October 23, 1924		6 AGE (IN YEARS (LAST BIRTHDAY)) 55 YRS.		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Roanoke Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH Clinical Center, Bethesda, Md.				12a USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) UNKNOWN		12b KIND OF BUSINESS OR INDUSTRY None			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE D.C. 13b COUNTY NONE 13c CITY OR TOWN Washington				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 417 New York Ave. NW 20001					
14 FATHER'S NAME FIRST MIDDLE LAST Monroe UNKNOWN Akers				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b (IF YES, GIVE WAR OR DATES) WWII 43048		16c SOCIAL SECURITY NO 223-24-1464		17 INFORMANT ADDRESS 435 W. Spicer Ave Mrs. Flora Akers, Wife Wildwood, NJ 08260					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pneumonitis 1509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) S/P resection of esophageal carcinoma										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 3, 1979, to March 2, 1980, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on above <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.											
22b SIGNATURE Robert M. Lester				DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT M. LESTER				22e ADDRESS National Institutes of Health Clinical Center, Bethesda, Md. 20205							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b DATE 3/6/80		23c NAME OF CEMETERY OR CREMATORY Cape May County Crematory Seaside Cemetery		23d LOCATION Lower Township, NJ Palermo Cape May N.J.			
24 FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME				ADDRESS 8653 Hempden Ave 20910 SILVER SPRING, MD.		25a DATE March 10, 1980		25b REGISTRATION SIGNATURE [Signature]			

30 100 0-1

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT



APPROVED FOR

MANAGEMENT

BY

DATE

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UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT NOTE: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must continue at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.				
1. FOR STATE REGISTRAR										07103				
1 DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a DATE OF DEATH		MONTH DAY YEAR		2b HOUR	
ROSANNE			W.				AIRINGTON		3		3		80	
3 SEX			4 RACE		5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE			White		03 31 13			66			MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH					
KENTUCKY			USA						Montgomery Co. MD.					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Rockville			Collingswood Nsg. Center						Social Worker		State of Cal.			
13a STATE					13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS			
Md.					Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12908 Margot Dr.			
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME									
CHARLES					Robinson					Emma Parkers				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS							
No					570-40-7696		Michael Mitchell-116 Stonegate Dr. S.S. Md.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY														
IMMEDIATE CAUSE (a) Cardiac Arrhythmia										3 min				
3989 DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
(b) Rheumatic Heart Disease										30 yrs.				
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
Chronic obstructive pulmonary disease														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
			HOUR A.M. MONTH DAY YEAR											
			P.M. 19											
21d INJURY OCCURRED			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION								
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET			CITY OR TOWN COUNTY STATE					
22a I certify that (1) this hospital attended the deceased from Oct 3, 19 79, to March 3, 19 80, that (1) (we) lost saw the deceased alive on Oct 3, 19 79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.														
22b SIGNATURE					DEGREE					22c DATE SIGNED				
James R. Moore Jr.					MD					3-3-80				
22d PHYSICIAN'S NAME (TYPE OR PRINT)					22e ADDRESS									
James R. Moore Jr.					207 Brookes Ave Gaithersburg Md.									
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION		COUNTY STATE				
Cremation			Mar. 4, 1980		Fort Lincoln Crem.			Brentwood		P.G. Md.				
24 FUNERAL DIRECTOR					25a DATE REC'D. BY REGISTRAR			25b REGISTRAR'S SIGNATURE						
NAME ADDRESS					MAR 6 1980			Anthony McCreedy						
Hines/Rinaldi F.H. 11800 N.H. Ave, Sil.Spr.														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8007704			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNIE B. ALEXANDER				MONTH DAY YEAR 3 4 80 245 PM			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 20 1893		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Waitress	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Sil. Spring				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST James Goodwin				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kathryn Free			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none		17 INFORMANT (daughter) ADDRESS Betty Ann Clark- (same as 13e)			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> <u>4140</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost b. <u>Arteriosclerotic Heart Disease</u> c. <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 days APPROX. 20 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Coronary Heart Failure Acute Respiratory Failure</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/20</u> 19 <u>80</u> to <u>3/4</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>3/4</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (b) (we) (I) did not view the body after death.							
22b. SIGNATURE Joseph B. Mizgerd, M.D.				DEGREE		22c. DATE SIGNED 3/4/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH B. MIZGERD, M.D.				22e. ADDRESS 7600 CARROLL AVE., TAKOMA PARK, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial,		23b. DATE 3-7-1980		23c. NAME OF CEMETERY OR CREMATORY Congressional		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, DC	
24. FUNERAL DIRECTOR Walter E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.				25a. DATE REC'D. BY REGISTRAR MAR 10 1980		25b. REGISTRAR'S SIGNATURE Ruthy McQueen	

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 0 0 7 7 0 5	
1. DECEASED NAME (TYPE OR PRINT) Margaret Allerdice					2a. DATE OF DEATH MONTH DAY YEAR 03/9/80			2b. HOUR 1925 M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 06-08-01		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery county MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adm. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD					13b. COUNTY Mont.		13c. CITY OR TOWN Guthrie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST HENRY NEFF					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLA GUNNETT						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577.030481		17. INFORMANT ADDRESS ROBERT ALLERDICE, MILTON, FLORIDA							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Arrhythmia DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 min 7 d.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Hypovolemia, Azotemia											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from March 3, 1980, to March 9, 1980, that (I) (we) last saw the deceased alive on March 9, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE James R. Moore Jr.				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-10-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 207 Brookes Ave Gaithersburg Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAR. 12, 1980		23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEMORIAL		23d. LOCATION CITY OR TOWN COUNTY STATE FROSTBURG, ALLEGANY, MD.					
24. FUNERAL DIRECTOR NAME DURST FUNERAL HOME, FROSTBURG, MD.				ADDRESS FROSTBURG, MD.		25a. DATE RECD. BY REGISTRAR MAR 20 1980		25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

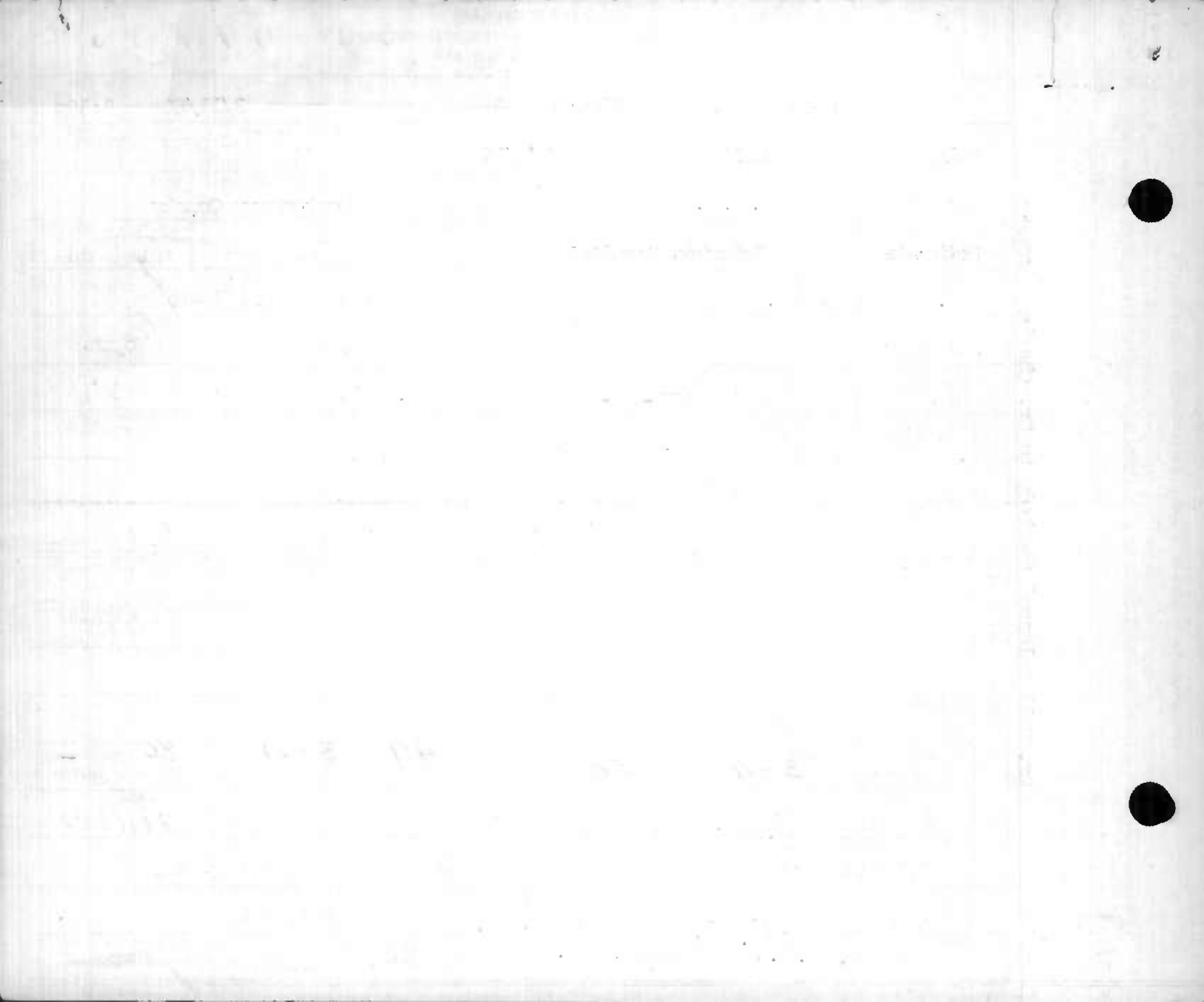
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Dr. Ball released the body to Dr. Charles Thompson

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR			2a. DECEASED NAME (TYPE OR PRINT) James Laurence Allnutt					2b. DATE OF DEATH MONTH DAY YEAR 3/11/80		2c. HOUR 9:50p M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7/8/15		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Treas. Perry Co.		12b. KIND OF BUSINESS OR INDUSTRY Oil Industry			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Montg.		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4303 Dannel Lane		
14. FATHER'S NAME FIRST MIDDLE LAST Laurence Allnutt			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Virginia Thomas								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WWII 577-03-1031		17. INFORMANT ADDRESS Carolyn C. Allnutt (Same as 13e)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial infarction</u> 2 hours										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>47</u> to <u>3-11</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>3-11</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles Thompson M.D.			DEGREE			22c. DATE SIGNED 3/11/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES W. THOMPSON			22e. ADDRESS 730-24-2 W. Wash Dr								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3-14-80		23c. NAME OF CEMETERY OR CREMATORY Monocacy Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Beallsville Md.			
24. FUNERAL DIRECTOR NAME Robert A. Humphrey Funeral Homes, P.A., Bethesda, Md.						25a. DATE REC'D. BY REGISTRAR MAR 24 1980		25b. REGISTRAR'S SIGNATURE M. J. McCreedy			



TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 07707						
1. DECEASED NAME (TYPE OR PRINT) JODIE EDDIE ASHMORE			2a. DATE OF DEATH MARCH 20, 1980			2b. HOUR 2130 M			
3. SEX MALE		4. RACE CAUC.		5. DATE OF BIRTH JAN. 29 1896		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C. CAROLINA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MARYLAND			13c. CITY OR TOWN MONTGOMERY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2004 ARCOLA AVE		
14. FATHER'S NAME FIRST MIDDLE LAST J. A. ASHMORE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PAULINE ASHMORE GREEN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 141B-144B 216-46-1025		17. INFORMANT (daughter) ADDRESS BETTY ANN FLICKINGER 2004 ARCOLA AVE WHEATON MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis complicating diffuse pneumonitis</u> 0389 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from MAR. 11, 19 80, to MAR. 20, 19 80, that (I) (we) last saw the deceased alive on MAR. 20, 19 80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert M. Hunt LT MC USN						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED MAR. 21 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert M. Hunt, LT MC USN						22e. ADDRESS NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3-25-80			23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION ARLINGTON ARLINGTON VA	
24. FUNERAL DIRECTOR NAME WARNER E. PUMPHREY			ADDRESS 4834 Ga. Ave MD. FURNAL HOME SILVER SPRING			25a. DATE REC'D. BY REGISTRAR MAR 27 1980		25b. REGISTRAR'S SIGNATURE History McCreedy	

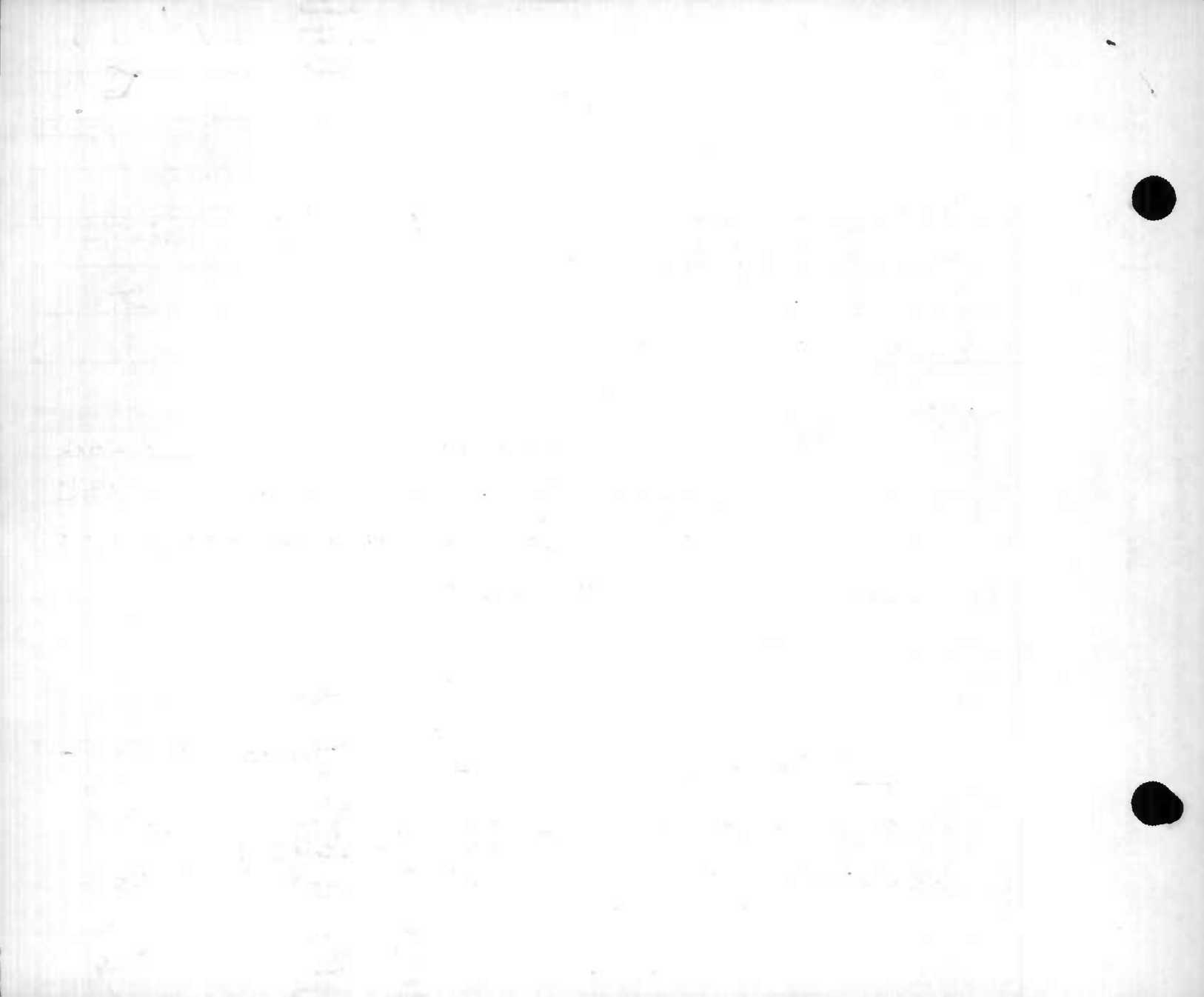
Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Whoyd ATKINS					2a. DATE OF DEATH MONTH DAY YEAR March 14 1980					2b. HOUR 8:15 A.M.
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 2 24 19		6 AGE (IN YEARS LAST BIRTHDAY) 61		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10 CITY OR TOWN OF DEATH Telcoma Park, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IS NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY P.G.		13c. CITY OR TOWN Thunderover		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6929 Allison St.		
14 FATHER'S NAME FIRST MIDDLE LAST Elmer C. ATKINS					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jessie Gray					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Unkn.					16b. SOCIAL SECURITY NO 242-18-6247		17 INFORMANT ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC TAMPONADE 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) MALIGNANT PERICARDIAL EFFUSION DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC LARGE CELL CARCINOMA (BLUR)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 1 WEEK 6 WEEKS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): DIABETES MELLITUS, VASCULITIS										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from FEBRUARY 10 1980 to MARCH 13 1980 , that (I) (we) last saw the deceased alive on MARCH 13 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.										
22b. SIGNATURE DEGREE James G. Brown MD						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/14/80		
23a. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES A. BROWN MD						22e. ADDRESS 6525 BELCREST RD HYATTSVILLE MD 20782				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 3/18/80		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Anatomy Board						ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR MAR 20 1980		
25b. REGISTRAR'S SIGNATURE History, Inc.										



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 0 7 7 0 9

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Eugenie M. Avore			2a. DATE OF DEATH MONTH DAY YEAR 3-12-80			2b. HOUR 6:30 P.M.								
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Jan. 6 1884		6. AGE (IN YEARS-LAST BIRTHDAY) 96 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) France		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.								
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed		12b. KIND OF BUSINESS OR INDUSTRY Retail Sales						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Massachusetts			13c. COUNTY Essex			13d. CITY OR TOWN Lawrence			13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13f. STREET ADDRESS 86 Dorchester St.		
14. FATHER'S NAME FIRST MIDDLE LAST Unknown Ziehler				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Madelaine Unknown										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 022-26-8974				17. INFORMANT Virginia Worthington ADDRESS 4956 Sentinel Dr. Sumner Md. 20016						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> 486- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 12, 1977</u> to <u>March 12, 1980</u> , that (I) (we) lost saw the deceased alive on <u>March 12, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Horace W. Bernton, M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/12/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Horace W. Bernton						22e. ADDRESS 4743 Bradley Blvd. Chevy Chase, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/19/80		23c. NAME OF CEMETERY OR CREMATORY Bellevue Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Lawrence Mass.						
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY HOMES, P.A., Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR MAR 20 1980		25b. REGISTRAR'S SIGNATURE L. J. Kelly						

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DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE													
1- FOR STATE REGISTRAR MARVIN E. AWKWARD CERTIFICATE OF DEATH													
REG. NO. 3 0 0 7 7 1 0													
1 DECEASED NAME (TYPE OR PRINT) MARVIN			FIRST E			LAST AWKWARD			2a DATE OF DEATH MONTH DAY YEAR 3/29/80		2b HOUR 8:40 a.m.		
3 SEX male			4 RACE black			5 DATE OF BIRTH MONTH DAY YEAR 4/16/32			6 AGE (IN YEARS LAST BIRTHDAY) 47 YRS			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10 CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver			12b KIND OF BUSINESS OR INDUSTRY				
13a STATE Maryland			13b COUNTY Montgomery			13c CITY OR TOWN Wheaton			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS 2811 Weisman Rd	
14 FATHER'S NAME FIRST MIDDLE LAST William Budd						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Janie Awkward							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 578-40-5429			17 INFORMANT ADDRESS Ernestine Awkward (wife) same as #13							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 2396 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Brain Tumor</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>paralysis, Inability to swallow</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 8 yrs													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a DATE OF OPERATION —			19b CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <u>10/1/80</u> 19 <u>79</u> , to <u>present</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>3/24</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE <u>Peter B. Sherer</u> MD						DEGREE MD			22c DATE SIGNED 3/29/80				
22d PHYSICIAN'S NAME (TYPE OR PRINT) Peter B. Sherer MD						22e ADDRESS 6410 Rockledge Dr. #308 Bethesda, Md. 20034							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 4-3-80			23c NAME OF CEMETERY OR CREMATORY Ash Memorial Cemetery			23d LOCATION CITY OR TOWN COUNTY STATE Sandy Spring, Montg. Md.				
24 FUNERAL DIRECTOR NAME George R. Snowden						24b ADDRESS 246 N. Washington Street Rockville, Md. 20850			25. DATE RECD. BY REGISTRAR APR 2 1980				
						25b REGISTRAR'S SIGNATURE <u>John J. McCready</u>							

MEDICAL CERTIFICATION

3701
BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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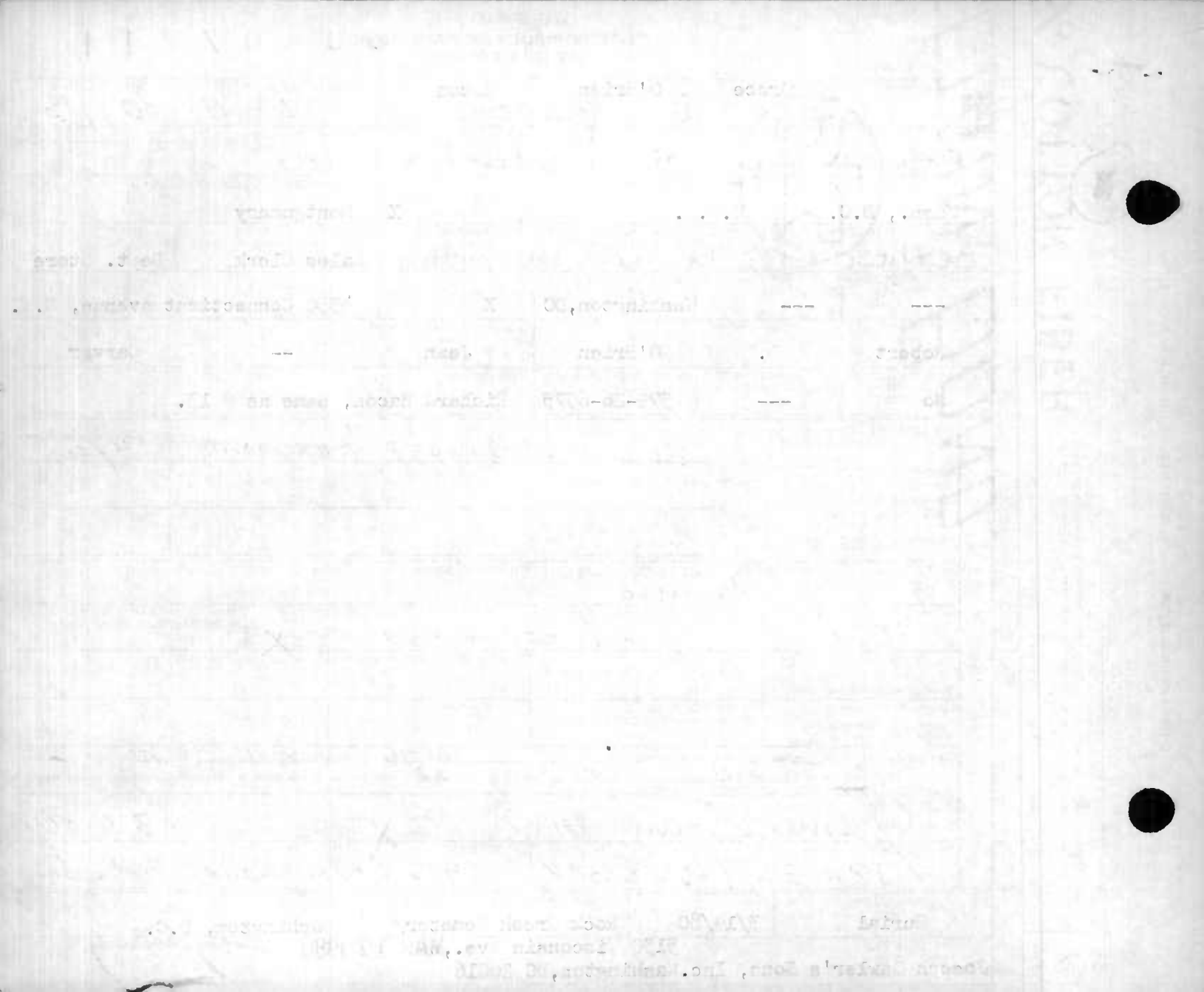
BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

07711

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
FIRST Grace MIDDLE O'Brien LAST Bacon		Female		White	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. MONTH DAY YEAR	
3/28/13		66		3/28/13	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
Wash., D.C.		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Bethesda		Suburban Hospital		Sales Clerk	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
-----		-----		Washington, DC	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
FIRST Robert MIDDLE L. LAST O'Brien		FIRST Jean MIDDLE --- LAST Carver		No	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
Richard Bacon, Same as # 13.		4550 Connecticut Avenue, N.W.		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Breast Carcinoma 1749 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. b) DUE TO, OR AS A CONSEQUENCE OF c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
Uremia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
1976		Breast Carcinoma		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22a. I certify that (1) (the hospital) attended the deceased from 3-11-80, to 3-11-80, that (1) (the) last saw the deceased alive on 3-11-80, and that in (my) (the) opinion death occurred on the date and hour and from the causes stated above, (1) (the) (did not) view the body after death.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		3/14/80		Rock Creek Cemetery	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		24c. LOCATION CITY OR TOWN COUNTY STATE	
Joseph Gawler's Sons, Inc.		5130 Wisconsin Ave., NW		Washington, D.C.	
25. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE SIGNED	
3-11-80		James W. Egan M.D.		3-11-80	
26. PHYSICIAN'S NAME (TYPE OR PRINT)		26b. ADDRESS		26c. DATE SIGNED	
JAMES W. EGAN		5413 Cedar Lane - Bethesda		3-11-80	



1980 MAR - 5 PM 1:17

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Film G542 4/15/80 186 dad

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 0 7 7 1 2

1- FOR STATE REGISTRAR		7- REG. NO.	
1 DECEASED NAME (TYPE OR PRINT)		2a DATE OF DEATH	
FIRST MIDDLE LAST WILLIAM K. BADEN		MONTH DAY YEAR 3/5/80	
3 SEX		2b HOUR	
Male		9:30 A.M.	
4 RACE		5 DATE OF BIRTH	
White		MONTH DAY YEAR Sept 19 1919	
6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR	
60 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8 BALTIMORE CITY OR COUNTY OF DEATH	
Wash DC		MONTGOMERY MD.	
9 CITY OR TOWN OF DEATH		10 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
SILVER SPRING		HOLY CROSS HOSPITAL	
11 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a STATE		12b KIND OF BUSINESS OR INDUSTRY	
Md.		Retired Fed. Government	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST Elmer L. Baden		FIRST MIDDLE LAST Elmira Doley	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.	
Yes		WW II 219-63-2243	
17 INFORMANT		ADDRESS	
Elizabeth B. Baden		4712 Sharon Rd. Camp Springs Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4232- IMMEDIATE CAUSE (a)			
DUE TO, OR AS A CONSEQUENCE OF			
(b)			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
Diabetes mellitus			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY	
		HOUR A.M. MONTH DAY YEAR P.M. 19	
21c INJURY OCCURRED		21d PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			
22a I certify that (I) (this hospital) attended the deceased from		22b LOCATION	
1-30, 19 80, to 3-6, 19 80, that (I) (we) lost saw the deceased alive on 3-5, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.		CITY OR TOWN COUNTY STATE Scitland Pr. Geo. Md	
22c SIGNATURE		22d DATE SIGNED	
Daniel J. Boyle		3-7-80	
22e PHYSICIAN'S NAME (TYPE OR PRINT)		22f ADDRESS	
Daniel J. Boyle		5103 Marlboro Pk. Hillside. Md	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE	
Burial		3/10/80	
23c NAME OF CEMETERY OR CREMATORY		23d LOCATION	
Cedar Hill Cemetery		CITY OR TOWN COUNTY STATE Scitland Pr. Geo. Md	
24 FUNERAL DIRECTOR NAME		25a DATE REC'D. BY REGISTRAR	
George P. Kals F.H. 6140 8800 Hill Rd		MAR 11 1980	
25b REGISTRAR'S SIGNATURE			
Ruthy McCreedy			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 0 7 7 1 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SAMUEL BAER			2a. DATE OF DEATH MONTH DAY YEAR 03 05 80			2b. HOUR 8:07 AM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 15, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Latvia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) P.G. PATIENT CARE CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Barber		12b. KIND OF BUSINESS OR INDUSTRY Barber Shop	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William Baer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Unknown			13e. STREET ADDRESS 10250 Westlake Drive, Apt. 105			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Alice Lyon, 18 Starlight Ct., Rockville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ① Senility								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
7070 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF ② Extensive aortic atherosclerosis									
DUE TO, OR AS A CONSEQUENCE OF ulcers & sepsis									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. peripheral vascular disease s/p bilateral A.R. amputation									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-13-80 to 3-5-80 , that (I) (we) lost saw the deceased alive on 3-5-80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE H. A. Molavi, M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3. 5. 80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. A. Molavi, M.D.			22e. ADDRESS 6005 Landover Rd Cheverly, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-7-80		23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Gdn.		23d. LOCATION CITY OR TOWN COUNTY STATE Olney, Montgomery, Maryland		
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEM. CHAP.			ADDRESS Rockville, Md.			25a. DATE REC'D. BY REGISTRAR MAR 11 1980		25b. REGISTRAR'S SIGNATURE H. A. Molavi	

BP

DHMH-16 20M
(VRA 15, 4) 7/78

STATION

WATER

03 02 40 00 00

PRINCE GEORGE'S COUNTY

R.G. PATIENT CARE CENTER

OVERLY

3 10 10 10

03 02 40 00 00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0 0 7 7 1 4			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST George D BAKER SR				2b. DATE OF DEATH MONTH DAY YEAR 3-9-80			
3 SEX MALE				4 RACE CAUCASIAN			
5 DATE OF BIRTH MONTH DAY YEAR 2 3 28				6 AGE (IN YEARS LAST BIRTHDAY) 52 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.				7b. CITIZEN OF WHAT COUNTRY? USA			
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.			
10 CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Truck Driver				12b. KIND OF BUSINESS OR INDUSTRY Giant Food			
13a. STATE md				13b. CITY OR TOWN P.G.			
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13d. STREET ADDRESS 6108 Quebec PLACE			
14 FATHER'S NAME FIRST MIDDLE LAST Donald D. Baker				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Guy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 127-16-4742			
16c. (IF YES, GIVE WAR OR DATES) W.W.II				17 INFORMANT ADDRESS Address Same as No# 13c. Phyllis M. Baker			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 1629 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Brain metastasis DUE TO, OR AS A CONSEQUENCE OF (c) } 1629 } (c) Fluid carcinoma of lung 540							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 317 1980 to 317 1980, that (I) (we) lost saw the deceased alive on 318 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE S. Dean		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/9/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDGAR H. LEVIN				22e. ADDRESS 823 FENNER ST.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-12-80		23c. NAME OF CEMETERY OR CREMATORY Md. Vet. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Md.	
24 FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyatts. Md.				25a. DATE REC'D. BY REGISTRAR MAR 12 1980		25b. REGISTRAR'S SIGNATURE H. H. H. H. H.	

Let Truck Driver Visit Food

0891 3 1 3AM

7. Michaelson's formula

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-5858.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		3 7 80		3 58		M	
2. SEX		3. RACE		4. DATE OF BIRTH		5. AGE (IN YEARS LAST BIRTHDAY)		6. BALTIMORE CITY OR COUNTY OF DEATH	
F		W		5 9 01		79		Rockville Montgomery Co. MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Czechoslovakia		USA							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Rockville		Adventist Grove		House Wife					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
		WV		Marion		Fairmont		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
(Not Available)		(Not Available)		NO		232011184		Fairmont WV	
								Record Of Deceased 414 Gaston Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1519		Metastatic Stomach Cancer		1519		Metastatic Stomach Cancer		months.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from		22b. I certify that (I) (this hospital) attended the deceased from		22c. DATE SIGNED					
3/7 19 80		3/7 19 80		3/7/80					
22a. SIGNATURE		22b. SIGNATURE		22c. DATE SIGNED					
Newman		Newman		3/7/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE SIGNED					
				MAR 14 1980					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
Burial		March 11 1980		Woodlawn		Fairmont		Marion WV	
24. FUNERAL DIRECTOR OR NAME		24. FUNERAL DIRECTOR OR NAME		24. FUNERAL DIRECTOR OR NAME		24. FUNERAL DIRECTOR OR NAME		24. FUNERAL DIRECTOR OR NAME	
Nick Domico Jr.		Nick Domico Jr.		Nick Domico Jr.		Nick Domico Jr.		Nick Domico Jr.	
414 Gaston Ave.		414 Gaston Ave.		414 Gaston Ave.		414 Gaston Ave.		414 Gaston Ave.	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

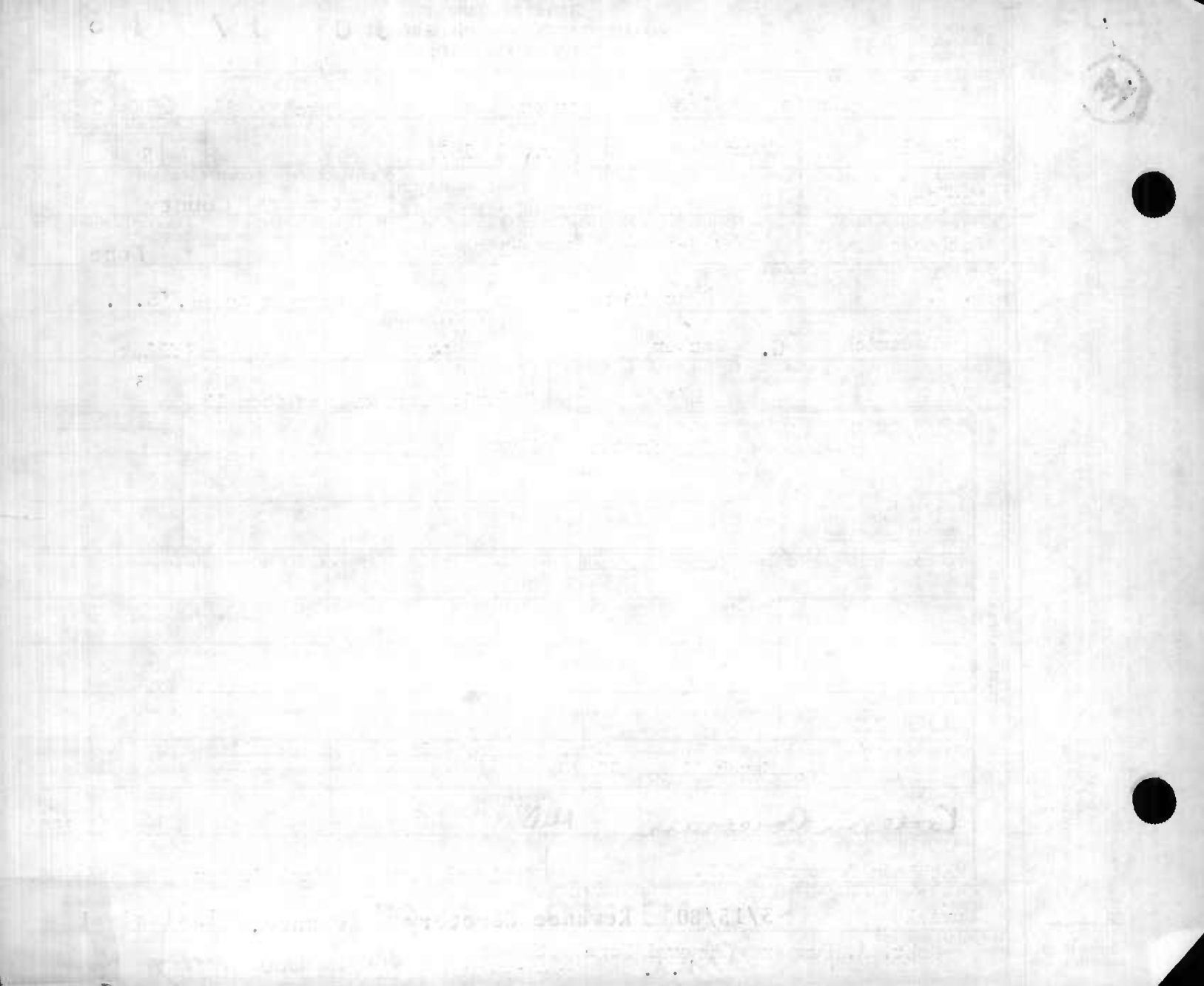
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Melanie Lee Barber				2b. HOUR 2:59P M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 6 1979		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 4 5	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY None	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D. C. 13b. COUNTY				13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Roderick C. Barber				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sharon Miller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Roderick Barber See item 13			
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 7991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (if (this hospital) attended the deceased from <u>Nov. 6</u> , 19 <u>79</u> , to <u>March 11</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>March 11</u> , 19 <u>80</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, (if (we) (did) (did not) view the body after death.							
22b. SIGNATURE Kathleen Corcoran				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED Mar. 12 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kathleen Corcoran, M.D.				22e. ADDRESS National Naval Medical Center, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/15/80		23c. NAME OF CEMETERY OR CREMATORY Kewanee Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Kewanee, Mississippi	
24. FUNERAL DIRECTOR NAME Robt. A. Pumphrey Funeral Home, Bethesda, P.A. Maryland				25a. DATE REC'D. BY REGISTRAR MAR 19 1980		25b. REGISTRAR'S SIGNATURE Marilyn McCrady	

BP



FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Dorothy Garrett Barnes			2a. DATE OF DEATH MONTH DAY YEAR 3/13/80			2b. HOUR 1:19P M			
3. SEX Female		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR Oct. 28, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Bethesda, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY Public Sch.	
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Indian Head		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Kitamaquand Cove	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Scott				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTIE unaviable GARRETT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 213-38-0946		17. INFORMANT ADDRESS Edgar R. Barnes same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic Adenocarcinoma 1991 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 2/24 19 77 , to 3/13 19 80 , that (I) (we) last saw the deceased alive on 3/7 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Stephen Newman			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/13/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen Newman, M.D.			22e. ADDRESS Bethesda, Maryland						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-16-80		23c. NAME OF CEMETERY OR CREMATORY Trinity Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf, Charles, Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Huntt Funeral Home Waldorf, Maryland				25a. DATE REC'D. BY REGISTRAR MAR 28 1980		25b. REGISTRAR'S SIGNATURE Dorothy McCreedy			

Released by Dr John Bled

MEDICAL CERTIFICATION

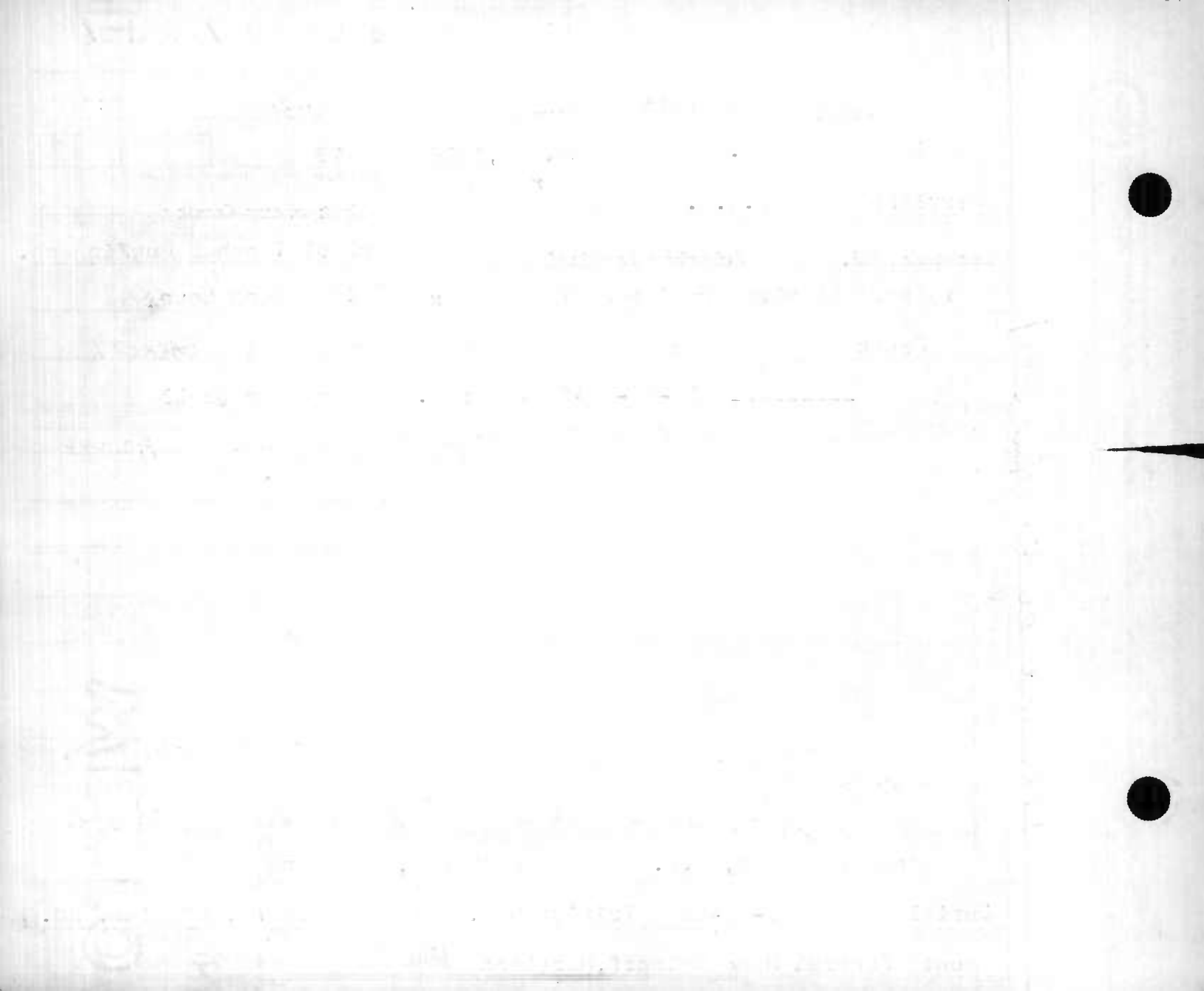
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/cremation permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for burial, cremation, or removal.

IMPORTANT: Item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner, the medical examiner must be notified of once.

BP _____

DHMH-16 20M
(VRA 15, 4) 7/78



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) <i>MOLLIE</i> MOLLIE <i>BARNEY</i> BARNEY		2a. DATE OF DEATH MONTH DAY YEAR <i>March 21, '80</i>		2b. HOUR <i>8:25</i> A M					
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR <i>APRIL 27, 1892</i>	6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	7 UNDER 1 YEAR <input type="checkbox"/> MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.						
10 CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SLIGO GARDENS NURSING HOME	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT	12b. KIND OF BUSINESS OR INDUSTRY GROCERY						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1220 BLAIR MILL ROAD						
14 FATHER'S NAME FIRST MIDDLE LAST <i>PINCUS</i> PINCUS <i>TUCKER</i> TUCKER	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>PECHE</i> PECHE <i>(UNKNOWN)</i> (UNKNOWN)								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO 212-74-4570	17. INFORMANT ADDRESS MILTON BARNEY, 14105 HERITAGE LANE, SILVER SPRING, MARYLAND							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>JULY 19 25</i> to <i>MARCH 21</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>February 6, 19 80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Robert L. Krichmar</i>		DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>MARCH 21 1980</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT L. KRICHMAR		22e. ADDRESS 7733 ALASKA AVENUE NW WASHINGTON D.C. 20012							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 3/23/1980	23c. NAME OF CEMETERY OR CREMATORY BETH SHOLOM CONGREGATION CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE HILLSIDE PR. GEO. MARYLAND						
24. FUNERAL HOME NAME RONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME		24b. ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D. C.		25a. DATE REC'D. BY REGISTRAR MAR 26 1980	25b. REGISTRAR'S SIGNATURE <i>Marking McBrady</i>				

NO 212-74-4570 MILTON BARNY, 1102 HERITAGE LANE, HAWAII

THESE THINGS TUCKER FEENE (UNKNOWN)

HAWAII, MONTGOMERY SILVER SPRING - K 1250 BLAIR HILL ROAD

TACOMA PARK SLIGO GARDENS NURSING HOME MERCHANT GROCERY

ROLAND U.S.A. XX MONTGOMERY

FEMALE WHITE APRIL 27, 1901 37

ALLIE BARNY

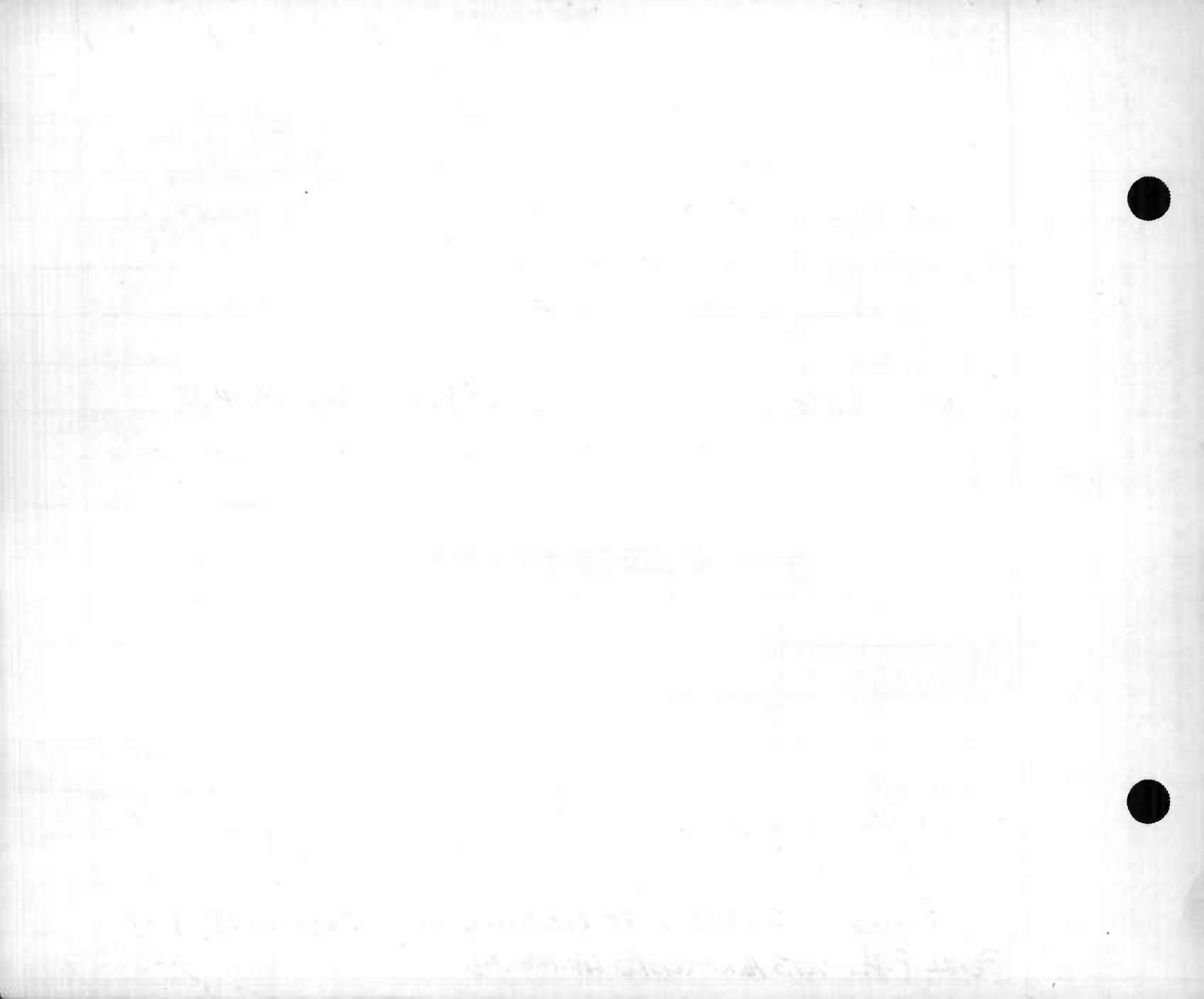
250 CARROLL STREET, N.W. WASHINGTON, D.C. MAY 1952
RONALD H. STEIN HEBREW MEMORIAL FUNERAL HOME
21271980 BETH SHOLOM CONGREGATION
HILLSTIDE T.W. GEO. HAWAII

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

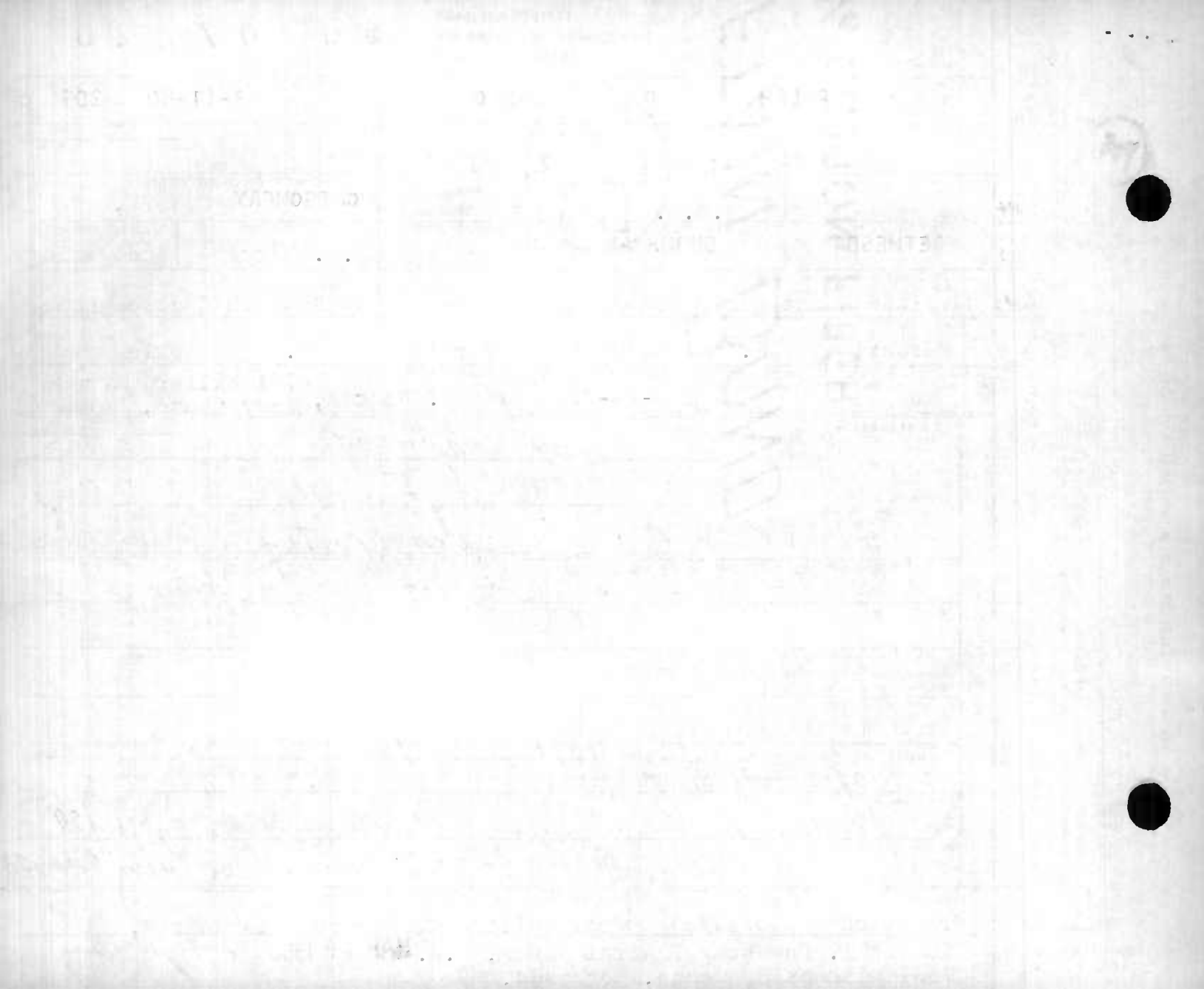
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 0 07719									
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
GERTRUDE J. BARRIERE								3-24-80		8:50 P.M.	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS. HOURS MIN.	
Female		WHITE		3 4 88		92 YRS					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		USA				MONTGOMERY MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Kensington, Md.		CIRCLE MANOR N.H. 10231 Carroll Pl.									
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS			
Maryland		P.G.		New Carrollton				5707-93rd Place			
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
George		Jennings		Susan		Portch					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT		ADDRESS					
NO		N/A		577-68-7625		LOUISE B. DOWNS		JANE AS #13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4292										years	
DUE TO, OR AS A CONSEQUENCE OF <u>disease</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Gastric ulcer & bleeding (re-ent)</u>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <u>8/19/76</u> to <u>7/29/80</u> , that (I) (we) lost saw the deceased alive on <u>7/24/80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If "not" (did) (did not) view the body after death.										22c. DATE SIGNED	
22b SIGNATURE <u>B.N. ROSENBAUM, M.D.</u> DEGREE										3/24/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>B.N. ROSENBAUM</u>										22e ADDRESS <u>3720 FARRAGUT AVE. KENSINGTON, MD. 20795</u>	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		27 MAR 80		Ft LINCOLN CEM		BRENTWOOD, MD					
24 FUNERAL DIRECTOR NAME <u>BEALL F.H.</u> ADDRESS <u>9013 ANNAPOLIS RD LANHAM, MD</u>										25a DATE OF REGISTRATION BY REGISTRAR <u>APR 2 1980</u> 25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 07720			
1. FOR STATE REGISTRAR										2a. DATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RALPH O BASCOM										MONTH DAY YEAR 3-11-80			
3 SEX Male										4 RACE Caucasian			
5. DATE OF BIRTH MONTH DAY YEAR 7/28/1902										6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas										7b. CITIZEN OF WHAT COUNTRY? U.S.A.			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY, MD.			
10. CITY OR TOWN OF DEATH BETHESDA										11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUBURBAN AREA, GIVE STREET ADDRESS) SUBURBAN HOSPITAL			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. Navy										12b. KIND OF BUSINESS OR INDUSTRY Accounting			
13a. STATE Maryland										13b. COUNTY Montgomery			
13c. CITY OR TOWN Bethesda										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Herbert J. Bascom										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carolyne G. Oxley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No										16b. SOCIAL SECURITY NO. 216-44-7521			
17. INFORMANT ADDRESS Alma D. Bascom, 4701 Willard Avenue, Chevy Chase, Maryland													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): 5908 Renal Shot Down, DUE TO, OR AS A CONSEQUENCE OF (b): Renal Failure, DUE TO, OR AS A CONSEQUENCE OF (c): Pyelonephritis, Diabetes Mellitus, Cerebral Vascular Accident.										INTERVAL BETWEEN CAUSE AND DEATH 2 Days 7 Days 14 Days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21c. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK NOT WORK <input type="checkbox"/>										21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21e. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (1) this hospital attended the deceased from 10/1 to 3/11/80, that (1) (was) last saw the deceased alive on 3/10/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death)													
22b. SIGNATURE Thomas N. Carter M.D.										22c. DATE SIGNED 3/11/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas N. Carter M.D.										22e. ADDRESS 5530 Wisconsin Ave Chevy Chase, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation										23b. DATE 3/15/80			
23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory										23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, VA			
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. 7557 Wisconsin Avenue, Bethesda, MD										25a. I HEREBY CERTIFY BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 19 1980			

BP



Cleared by Dr. Ball



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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 DHMM-16 25M
 (VRA 15, 4) 1/79

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

B 0 0 7 7 2 1

 FOR
 STATE
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MURDENA J BATEASE			2a. DATE OF DEATH MONTH DAY YEAR March 28, 1980			2b. HOUR 9A M		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 12, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vermont		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3 Drake Court			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. STREET ADDRESS 3 Drake Court		
14. FATHER'S NAME FIRST MIDDLE LAST John Smith				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Ayres				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 009-14-9387		17. INFORMANT ADDRESS Bethesda, MD Mrs. Eugene S. Day, 1007 Holmhurst Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular disease, atherosclerotic 4370 DUE TO, OR AS A CONSEQUENCE OF (b) Associated with Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Abdominal Aneurysm								
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED none		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. none 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) none				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) none		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (the hospital) attended the deceased from Dec 19 70 to March 20 19 80, that (1) (two) lost saw the deceased alive on March 20 19 80, and that in (my) (their) opinion death occurred on the date and hour and from the causes stated above. (1) (two) (did) (did not) view the body after death.								
22b. SIGNATURE Allen J. O'Neill M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/28/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Allen J. O'Neill, M.D.				22e. ADDRESS 8601 Old Georgetown Rd. Bethesda, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-30-80		23c. NAME OF CEMETERY OR CREMATORY Scottsville Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Danby VT		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR APR 2 1980		25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

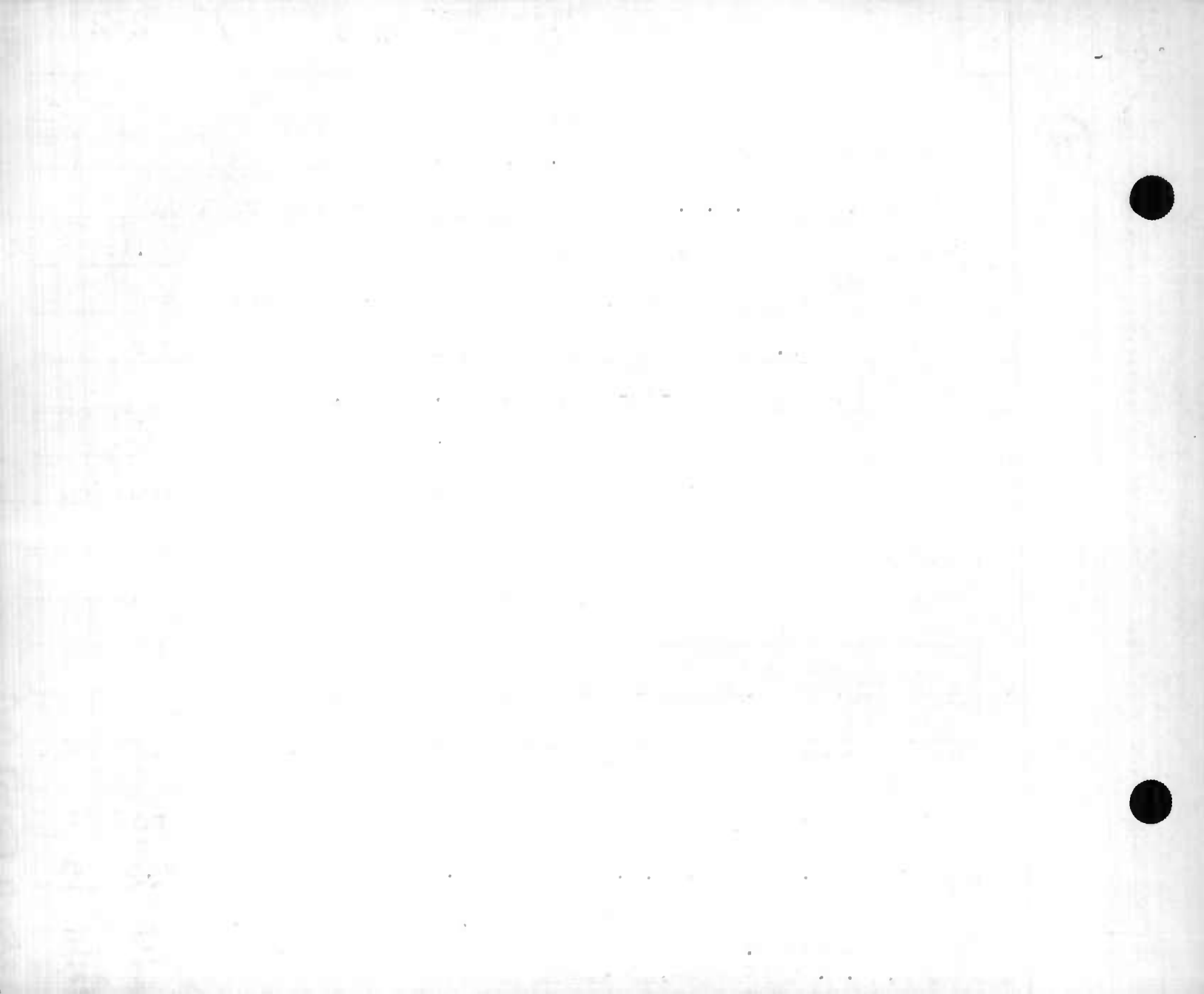
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or on call.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																					
1. FOR STATE REGISTRAR			REG. NO.																		
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR				
Hazel			NMI		Beall				3		7		80		920 P		M				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS						
FEMALE			Caucasian			Feb. 4, 1918			62			MONTHS			DAYS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH												
Washington, DC			U.S.A.						Montgomery County			MD.									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY												
Bethesda			7819 Moorland Lane			Teacher			Public School												
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS									
Maryland			Montgomery			Bethesda			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			7819 Moorland Lane									
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																		
Byron			S. Beall			Hazel			Spear												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS												
Yes			WW II			220-44-2362			Hazel S. Beall, Same as #13												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROPRIATE INTERVAL BETWEEN DEATH AND DEATH											
IMMEDIATE CAUSE (a) Probable Pneumonia										days											
1749 DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Breast Cancer										months											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																					
DUE TO, OR AS A CONSEQUENCE OF (c)																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
			P.M.			19															
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			CITY OR TOWN			COUNTY			STATE						
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET															
22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 1975, to 3/7, 1980, that (I) (we) lost saw the deceased alive on 3/6, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (did) (did not) view the body after death.																					
22b. SIGNATURE										DEGREE										22c. DATE SIGNED	
Stephen J. Newman										MD										3/7/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS											
Stephen J. Newman, M.D.										5411 W. Cedar Lane Bethesda, MD 20014											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			CITY OR TOWN			COUNTY			STATE			
Burial			3/10/80			Parklawn Mem. Park			Rockville, Maryland												
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE	
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland										MAR 11 1980										History McCreedy	

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DHMH-16 20M
(VRA 15, 4) 7/78



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

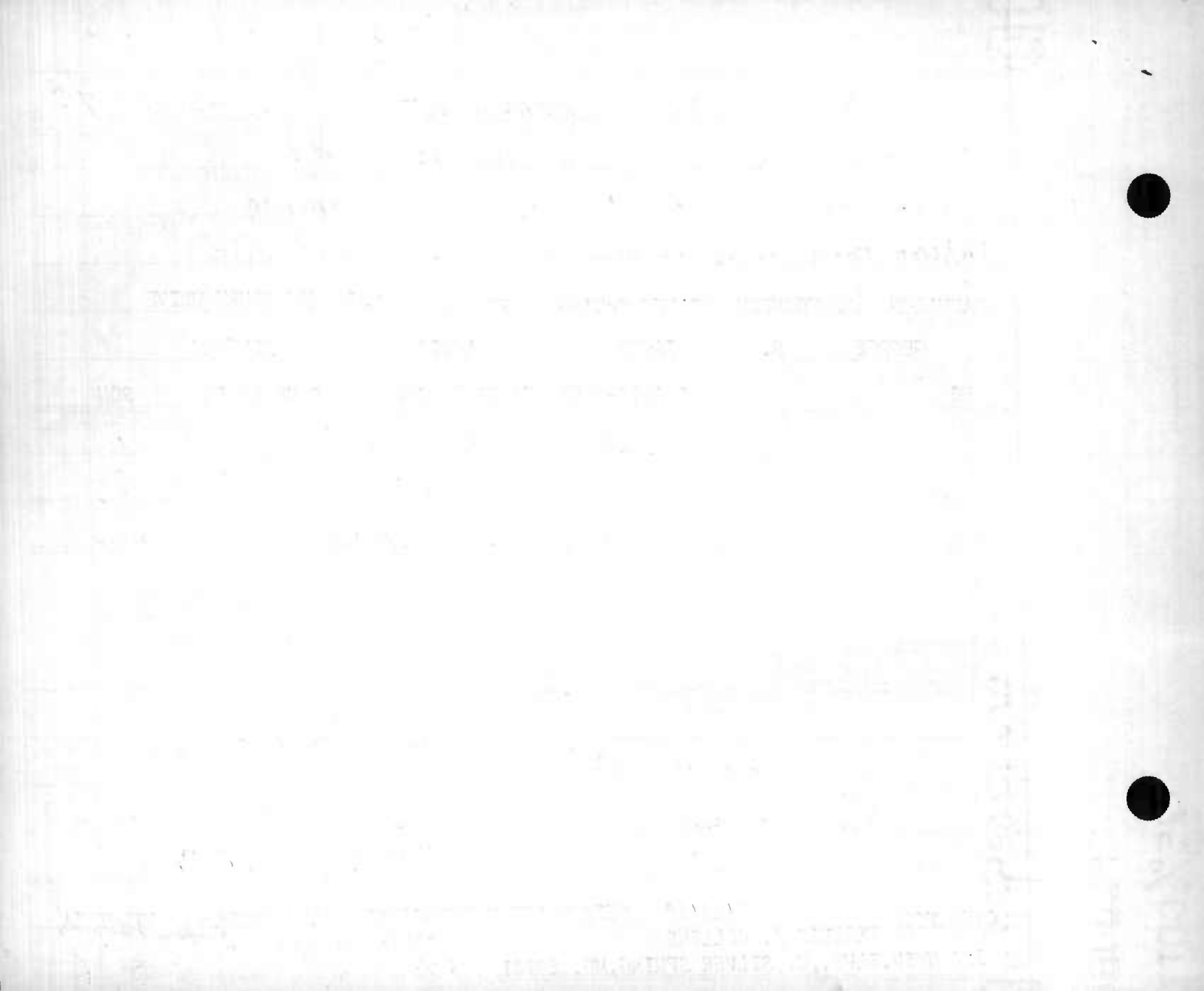
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			
			VERA J. BEAUMONT			3-25-80			7:30 P.M.			
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
FEMALE			C		11 15 90			89		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
PHILA. PA			U.S.A.					MONTG.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
TAKOMA PARK			SLIGO GARDENS Nursing Home						Housewife			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
MARYLAND			MONTGOMERY		SILVER SPRING			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9210 KINGSBURY DRIVE		
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME						
GEORGE S. JAMES						LOUISA SENTMAN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
NO						196-20-0555		JAMES D. SHAW SAME AS 13 SON				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4659 IMMEDIATE CAUSE (a) Cardiac-respiratory arrest										minutes		
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
(b) Cognitive heart failure										minutes		
DUE TO, OR AS A CONSEQUENCE OF												
(c) Upper Respiratory Infection										hours		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
Cocaine Abuse, Arteriosclerosis												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
			HOUR A.M. MONTH DAY YEAR									
			P.M. 19									
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION						
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>						CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from January 19 79, to March 25 19 80, that (I) (we) last saw the deceased alive on February 22 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (I) did not view the body after death.												
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
HUGO G. GRAZIANI			MD						3-25-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS						
HUGO G. GRAZIANI						800 PERSHING DR 303A SILVER SPRING MD 20910						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION				
CREMATION			3/26/80		METROPOLITAN CREMATORY			ALEXANDRIA VIRGINIA				
24. FUNERAL DIRECTOR						25a. DATE OF DEATH			25b. REGISTRATION SIGNATURE			
FRANCIS J. COLLINS						MAR 26 1980						
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901												

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DHMH-16 20M
(VRA 15, 4) 7/78



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										07724 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) William K. Beavers										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 3-23-80	
3. SEX Male 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR Dec. 11 1932 6. AGE (IN YEARS) LAST BIRTHDAY 47 YRS.										7b. HOUR 12:30 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C. 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										2c. DATE PRONOUNCED DEAD March 23, 1980 2d. HOUR 12 PM	
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.											
10. CITY OR TOWN OF DEATH Rockville 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Hospital										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician	
12b. KIND OF BUSINESS OR INDUSTRY Elec. Co.											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 1714 Crawford Drive											
14. FATHER'S NAME FIRST MIDDLE LAST Patrick D. Beavers										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Kloman	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) Korean										16b. SOCIAL SECURITY NO. 577-46-1088	
17. INFORMANT ADDRESS Noreen C. Beavers, Wife. Same as item 13.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency Acute 411- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Ball M.D. Deputy MEDICAL EXAMINER										DATE SIGNED March 23, 1980	
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D. ADDRESS 7936 Old Georgetown Rd., Bethesda, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 3/26/1980	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery										23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland.	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons Inc. ADDRESS 5130 Wisc. Ave., N.W. Wash., D.C.										25a. DATE REC'D. BY REGISTRAR MAR 31 1980	
25b. REGISTRAR'S SIGNATURE Anthony M. Brady											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. SUMMARY

2. STATE OF THE ART

3.

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6. REFERENCES

7. CONCLUSIONS

8.

9.

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16. DISTRIBUTION STATEMENTS

17.

18.

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21. DISTRIBUTION STATEMENTS

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24.

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Info. added 3/26/80 bal

STATE OF MARYLAND

07725

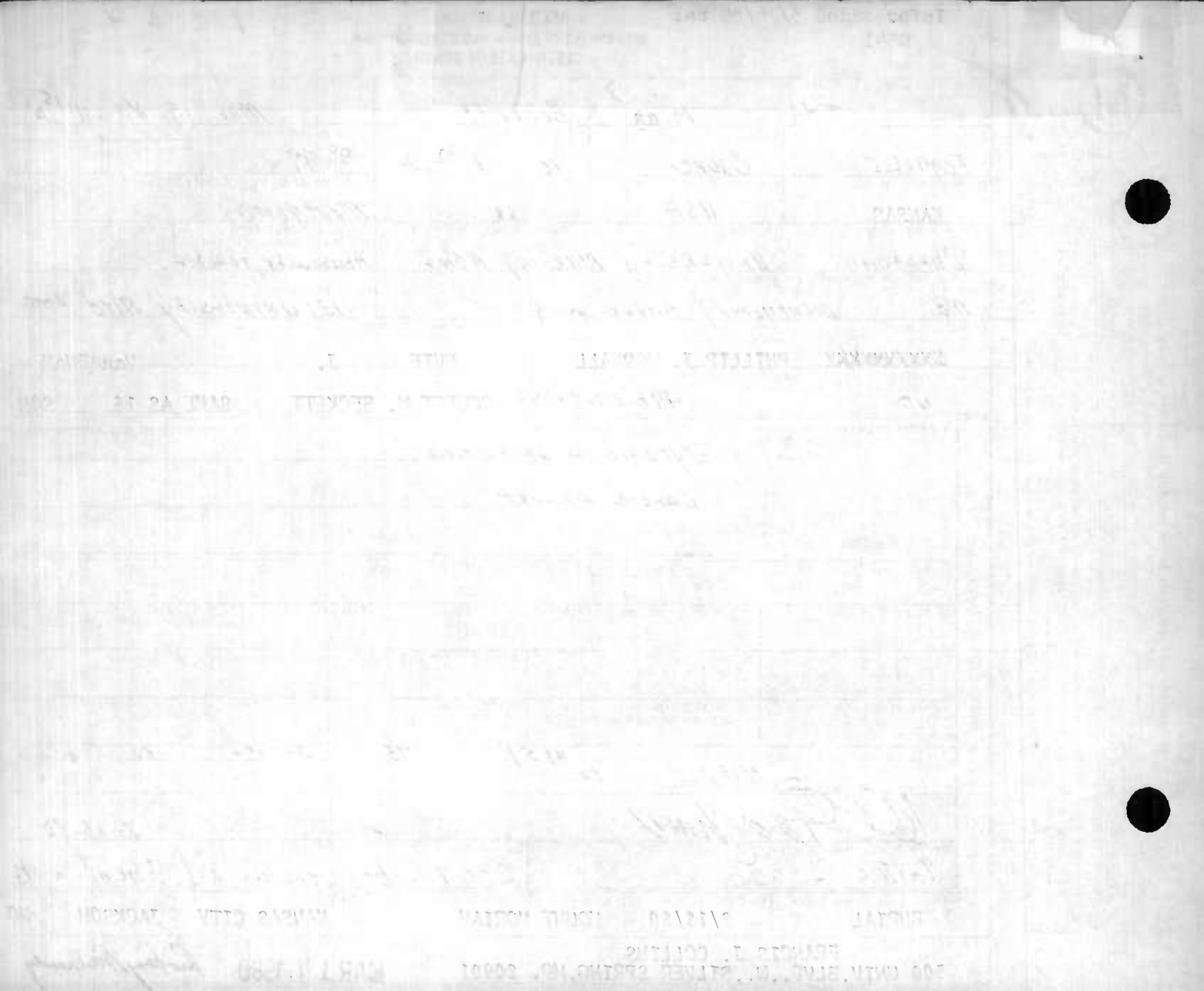
1- FOR G541
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) IDA M. BECKETT			2a. DATE OF DEATH MONTH DAY YEAR MAR. 15-80			2b. HOUR 11:15 A.M.				
3. SEX FEMALE		4. RACE CWAC		5. DATE OF BIRTH MONTH DAY YEAR 10 9 8182		6. AGE (IN YEARS LAST BIRTHDAY) 98 99		7. IF UNDER 1 YEAR MONTHS DAYS YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KANSAS		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife, teacher		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD.			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1131 UNIVERSITY BLVD. West	
14. FATHER'S NAME FIRST MIDDLE LAST XXXXXXXXXX PHILIP T. WORRALL			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVIE J. VAN ARMAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 496-07-8429D		17. INFORMANT ROBERT W. BECKETT		18. SAME AS 13 SON			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARDIC ARREST DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 11/3/ , 19 75 , to 3-15- , 19 80 , that (we) last saw the deceased alive on 3/13/ , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we) saw the body after death.										
22b. SIGNATURE Walter Goozh						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-15-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Walter Goozh						22e. ADDRESS 2309 Shorefield Rd Wheaton MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3/18/80		23c. NAME OF CEMETERY OR CREMATORY MOUNT MORIAH		23d. LOCATION CITY OR TOWN COUNTY STATE KANSAS CITY JACKSON MO			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						25a. DATE REC'D. BY REGISTRAR MAR 17 1980		25b. REGISTRAR'S SIGNATURE Anthony McCreedy		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201





STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CHARLES Henry		MIDDLE BEHNEY		LAST BEHNEY		2a. DATE OF DEATH MONTH DAY YEAR 3 18 80		2b. HOUR 11:35 A.M.	
3. SEX M Male		4. RACE W White		5. DATE OF BIRTH MONTH DAY YEAR 11 5 17		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Takoma Park Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Retail	
13a. STATE MD.		13b. COUNTY PG.		13c. CITY OR TOWN Upper Marlboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12509 Cynthia Court	
14. FATHER'S NAME FIRST MIDDLE LAST Ray		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Seyfert		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 170 07 3348		17. INFORMANT Mary Jane Behney	
16c. ADDRESS Same as #13									

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART I. DEATH WAS CAUSED BY:

2028
IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

MEDICAL CERTIFICATION

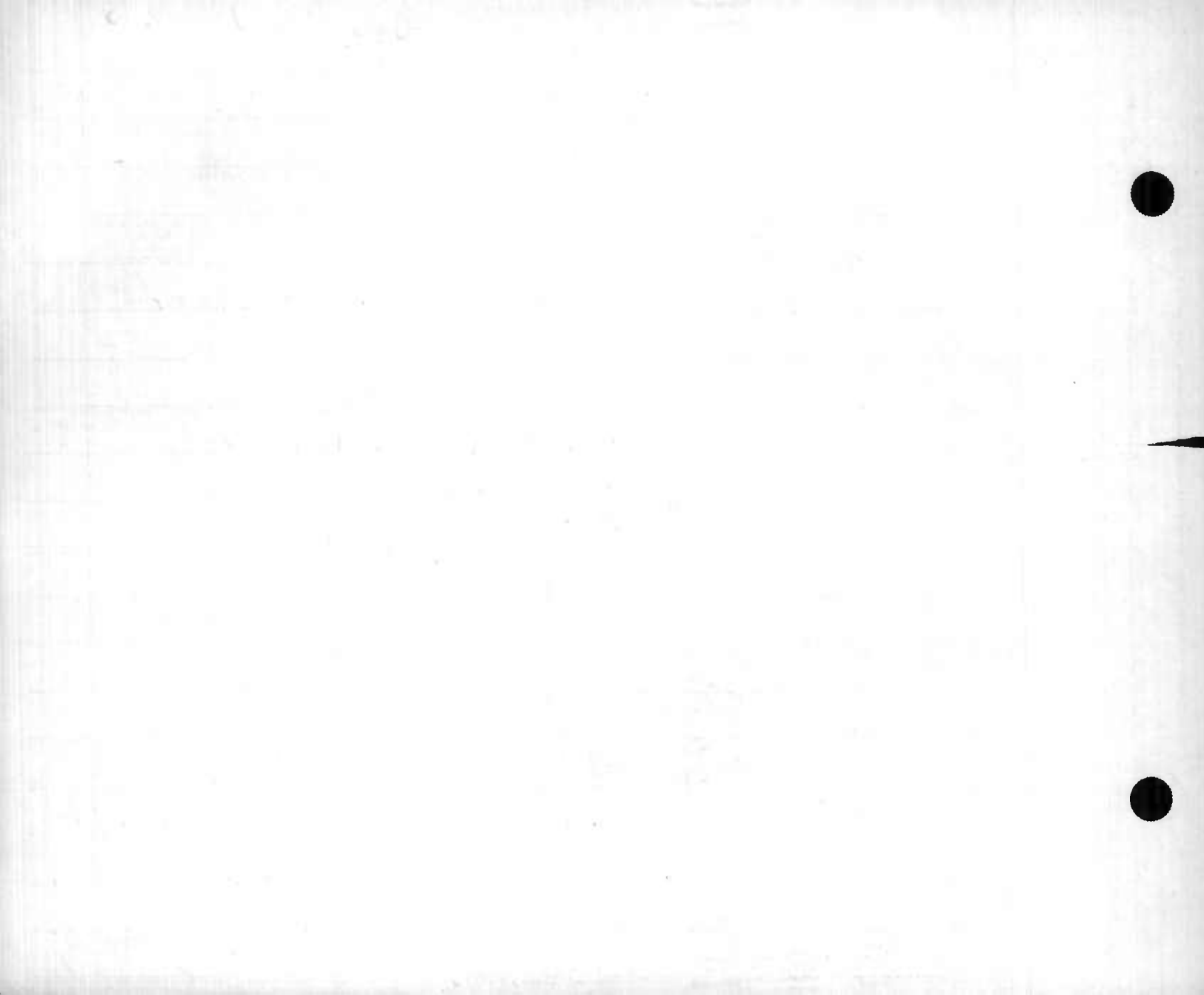
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/18 19 80 , to 3/18 19 80 , that (I) (we) last saw the deceased alive on 3/18 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Lewis H. Dennis		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/18/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis H. Dennis, M.D.		22e. ADDRESS 831 University Blvd Silver Spring, Md.					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 21 Mar 1980		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton PG Md.	
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm		ADDRESS Funeral Home Inc		25a. DATE RECEIVED BY REGISTRAR MAR 21 1980		25b. REGISTRAR'S SIGNATURE John McCreedy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH07728
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		3. MONTH		4. DAY		5. YEAR		6. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. DATE PRONOUNCED DEAD	
Mary E. Betters		Female		Black		Oct. 2, 1906		73 YRS.		3 1 1980	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	
Md.		U.S.A.		WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery County, MD		Pooleville		19140 Martinsburg Road	
12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Housewife		Md.		Montg.		Pooleville		YES <input type="checkbox"/> NO <input type="checkbox"/>		19140 Martinsburg Road	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
Festus Nelson		Annie Holland		No				Henrietta Warfield (Sister) Balt, Md.		PART 1 DEATH WAS CAUSED BY:	
										IMMEDIATE CAUSE (a) Smoke and soot inhalation & Acute carbon monoxide intoxication	
										DUE TO, OR AS A CONSEQUENCE OF	
										(b)	
										DUE TO, OR AS A CONSEQUENCE OF	
										(c)	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?							
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		2:51 P.M. 3 1 1980		house fire							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION							
		house		19140 Martinsburg Rd, Pooleville, Mont. MD							
22. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22a. I certify that I took charge of the remains described above, held on death resulted from:		TITLE (SPECIFY)		DATE SIGNED							
ACTUAL SIGNATURE		Deputy Chief		3/3/80							
EXAMINER'S NAME		ADDRESS									
Thomas D. Smith, M.D.		111 Penn St. Balto., MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		3-6-80		Warren Cemetery		Martinsburg, Montg. Md.					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
George R. Snowden		MAR 6 1980		Mickey McCreedy							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 1 AND 2 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Oct. 5, 1906

XX

Providence

Providence

Providence

Providence

George E. Gordon
245 N. Washington Street
Providence, R.I. 02903

Providence

3-4-80

Providence

Providence

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER MUST EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR OFFICE. GIVE PAGE 4 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

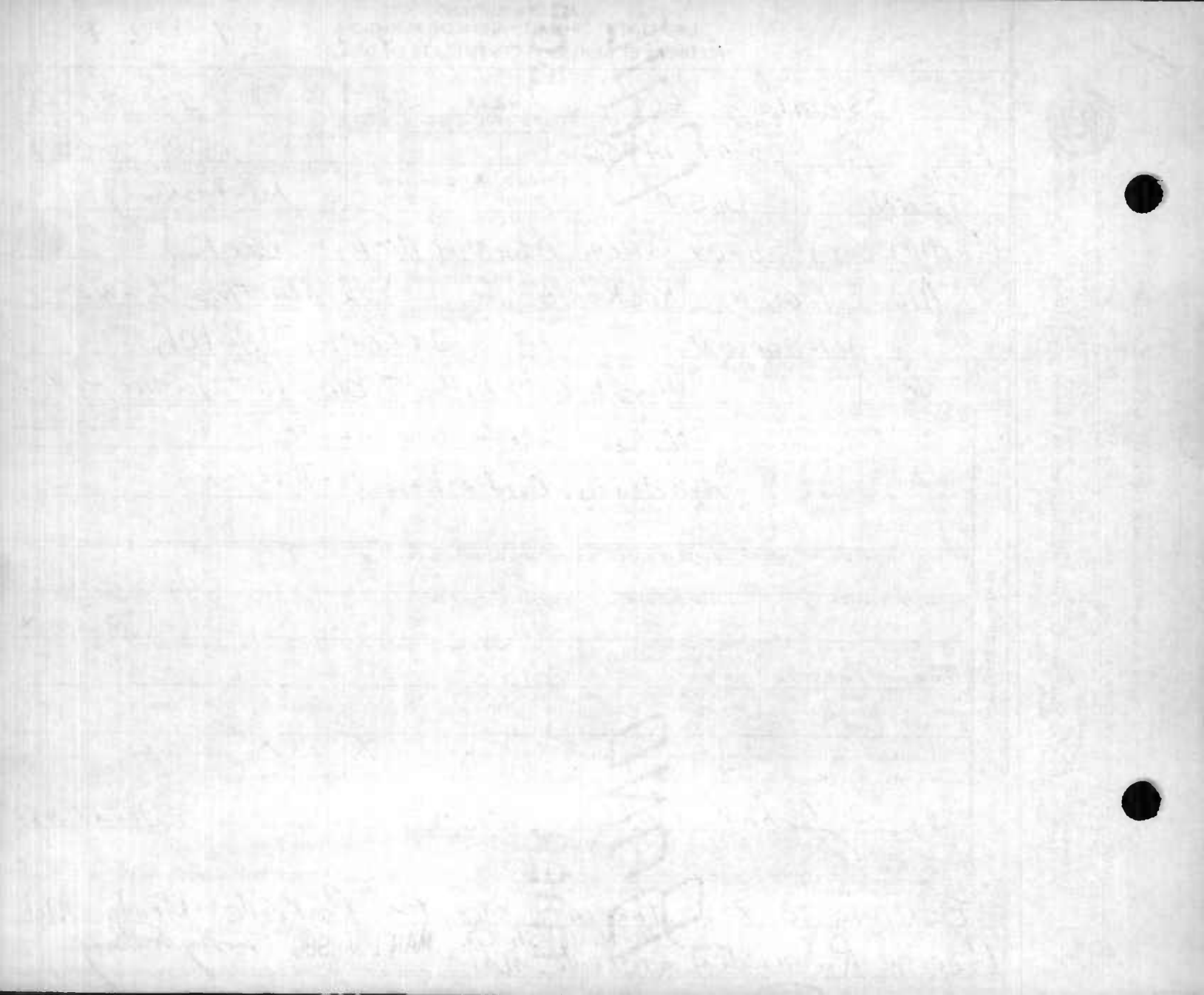
DHM-17
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15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07729
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Sammie L. Blair SR.			2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 3-5 1980			2b. HOUR 6:40 AM				
3. SEX M	4. RACE N	5. DATE OF BIRTH MONTH 03 DAY 04 YEAR 24	6. AGE (IN YEARS) LAST BIRTHDAY 56 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN 	2c. DATE PRONOUNCED DEAD March 5 1980			2d. HOUR 6 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENN.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE Adventist Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COOK		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY Montg		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 22 MARTINS LANE
14. FATHER'S NAME FIRST UNKNOWN MIDDLE LAST 			15. MOTHER'S MAIDEN NAME FIRST DOROTHY MIDDLE Welch LAST 							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 412-26-6887		17. INFORMANT ADDRESS Arthur T. Blair (wife) Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency Acute 411- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Hypertensive Cardio-Vascular Disease (c) 									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE John S. Ball			TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER			DATE SIGNED March 5, 1980	
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS							
23a. BURIAL, CREMATION, REMOVAL			23b. DATE 3-8-80		23c. NAME OF CEMETERY OR CREMATORY PARKLAWN Mem. Pk.			23d. LOCATION CITY OR TOWN Rockville COUNTY Montg STATE Md.		
24. FUNERAL DIRECTOR NAME George R. Snowden ADDRESS 246 N. Wash. St. Rockville, Md.			25. DATE REC'D BY REGISTRAR MAR 10 1980			25a. REGISTRAR'S SIGNATURE Helen M. Brady				

0901



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Wayne C. Bobst			2a. DATE OF DEATH MONTH 3 DAY 28 YEAR 80		2b. HOUR 10:35 M
3 SEX Male	4 RACE Caucasian	5 DATE OF BIRTH MONTH 3 DAY 9 YEAR 9		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10 CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrator Retirement Home		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST Robert MIDDLE Bobst LAST Grace			15 MOTHER'S MAIDEN NAME FIRST Grace MIDDLE Evansizer LAST Evansizer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215 42 8547		17 INFORMANT ADDRESS Elizabeth A. Bobst Same as item 13 a-e	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Edema 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Acute Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Anoxia after cardiac arrest					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours hours hours
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Bronchitis, Corneal Ulcer, Deep Vein Thrombosis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from March 27 19 80 to March 28 19 80 , that (I) (we) last saw the deceased alive on March 27 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Harold M. Kenner MD			DEGREE MD		22c. DATE SIGNED 3/28/80
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD M. KENNER MD			22e. ADDRESS 10401 Old Georgetown Rd Bethesda MD 20814		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-31-80		23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park	
23d. LOCATION CITY OR TOWN Rockville		COUNTY Mont.		STATE Maryland	
24 FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852			25a. DATE REC'D. BY REGISTRAR APR 3 1980		25b. REGISTRAR'S SIGNATURE Pitney Kellogg

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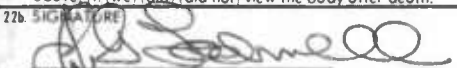
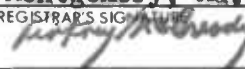
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George Wesley BOYER			2a. DATE OF DEATH MONTH DAY YEAR March 19, 80			2b. HOUR 1 P M			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 12 25 11		6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD.			
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery Gen..Hospital,				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Merchant		12b. KIND OF BUSINESS OR INDUSTRY Hardware	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Damascus		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST George M. Boyer			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Marie Bowman			13e. STREET ADDRESS 26700 Howard Chapel Dr.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-12-3724		17. INFORMANT ADDRESS Willie Drye Boyer, Item 13				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY Small Cell Carcinoma of (R) Lung IMMEDIATE CAUSE (a) 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from August 19 79 to March 19 80 , that (I) (we) last saw the deceased alive on March 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 						DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3.19.80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN G LODMELL, M.D.						22e. ADDRESS 18111 Prince Philip Dr..OLNEY, Md..20832			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar..22, 1980		23c. NAME OF CEMETERY OR CREMATORY Damascus Meth.		23d. LOCATION CITY OR TOWN COUNTY STATE Damascus, Montgomery, Md.		
24. FUNERAL DIRECTOR NAME Olvin L. Molesworth, Damascus, Md.						25a. DATE REC'D. BY REGISTRAR MAR 24 1980		25b. REGISTRAR'S SIGNATURE 	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR												DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				07732 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)						FIRST MIDDLE LAST — Robert Stevenson Boyle						2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> 3-7 1980				2b. HOUR 5:45 AM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Apr. 8 1929		6. AGE IN YEARS (LAST BIRTHDAY) 50 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD March 7 1980				2d. HOUR 6:20 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD							
10. CITY OR TOWN OF DEATH Gaithersburg				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 57 Long Meadow Drive								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. Navy				12b. KIND OF BUSINESS OR INDUSTRY Dental Tech.			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 57 Longmeadow Drive											
14. FATHER'S NAME FIRST MIDDLE LAST Albert Boyle						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Zelma Lucas													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 1951-80		17. INFORMANT Mrs. Anna L. Boyle				ADDRESS See item 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410- Old myocardial infarction with acute extension</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <i>John C. Ball</i>				TITLE (SPECIFY) M.D. <i>Deputy</i>				MEDICAL EXAMINER				DATE SIGNED March 7, 1980							
EXAMINER'S NAME (TYPE OR PRINT) John C. Ball, M.D.				ADDRESS 7936 Old Georgetown Rd, Bethesda, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE MARCH 11, 1980				23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Lock Haven Clinton PA							
24. FUNERAL DIRECTOR NAME W. W. Chambers Co.				ADDRESS Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR MAR 13 1980				25b. REGISTRAR'S SIGNATURE <i>Patricia McCreedy</i>							

Boyle

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARY		FIRST BRADLEY		MIDDLE BRADLEY		LAST BRADLEY		2a. DATE OF DEATH MONTH 03 DAY 05 YEAR 80				2b. HOUR 6 25 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 07 DAY 29 YEAR 1888		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		IF UNDER 1 YEAR MONTHS 00 DAYS 00		IF UNDER 24 HRS HOURS 00 MIN 00			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery				MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Retirement Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home					
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8700 Jones Mill Road,					
14. FATHER'S NAME FIRST Unknown MIDDLE Miller LAST Miller		15. MOTHER'S MAIDEN NAME FIRST Unknown MIDDLE Unknown LAST Unknown											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none		17. INFORMANT (Atty) Peter R. Hartogensis		ADDRESS 850 Sligo Ave.		S.S. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRCULATORY COLLAPSE 4392 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIAC AND GENERALIZED VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Bronchitis - Emphysema													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22. I certify that (I) (this hospital) attended the deceased from Feb 22 , 19 80 , to MARCH 5 , 19 80 , that (I) (we) lost saw the deceased alive on Feb 22 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death													
23a. SIGNATURE Robert L. Krichmar		DEGREE MD		23b. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				23c. DATE SIGNED MARCH 5 1980					
23d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT L. KRICHMAR		23e. ADDRESS 7733 BLASKA AVENUE D.W. WASHINGTON D.C. 20012											
24a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		24b. DATE 3-6-80		24c. NAME OF CEMETERY OR CREMATORY Metropolitan				24d. LOCATION CITY OR TOWN Alexandria COUNTY Fairfax STATE Va.					
24e. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.		24f. DATE REC'D. BY REGISTRAR MAR 11 1980		24g. REGISTRAR'S SIGNATURE History McBrady									

COMMUNICATIONS
SECTION
U.S. AIR FORCE
WASHINGTON, D.C.

RECEIVED
JAN 10 1950
AIR FORCE
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.		0 0 7 7 3 4					
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR	
FIRST Mabel E. Brannon				MONTH DAY YEAR March 17 1980				11:28 ^A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR	
FEMALE		CAUCASIAN		MONTH DAY YEAR Nov. 20 1911		68 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
WASHINGTON, D.C.		U.S.A.				MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
ROCKVILLE		SHADY GROVE ADVENTIST HOSPITAL				RETIRED SECY.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MARYLAND		MONTGOMERY		GAITHERSBURG		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		17750 TOWNE CREST DRIVE	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST FRANK DAVIS				FIRST MIDDLE LAST FLORENCE VALENTINE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS			
NO				578-07-8588		LAWRENCE A. SPRINGIRTH 17730 TOWNE CREST DR.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>								1 Hour	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardio-vascular Disease</u>								75 yr.	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Obstructive Airways Disease</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>October 11, 1979</u> , to <u>March 17, 1980</u> , that (I) (we) last saw the deceased alive on <u>March 17, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
<u>Frank J. Mayo</u>				M.D.				3-17-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
Frank J Mayo				16220 Frederick Road Gaith., Md.					
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY STATE	
BURIAL		3-21-80		GLENWOOD CEMETERY		WASHINGTON D.C.			
24. FUNERAL DIRECTOR NAME				ADDRESS		DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
ROBERT A. PUMPHREY FUNERAL HOMES P/A				ROCKVILLE MD.		MAR 26 1980		<u>Frank J Mayo</u>	

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OF

WASHINGTON, D.C. 20540

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CHIEF OF BUREAU

DEPT. OF EDUCATION

WASHINGTON, D.C.

ADMINISTRATIVE

DEPT. OF EDUCATION

WASHINGTON, D.C.

ADMINISTRATIVE

DAVIS

EDUCATION

NOV

07-0222, LAURENCE A. BRIDGES

LAURENCE A. BRIDGES, 1730 17TH ST. N.W., WASHINGTON, D.C. 20036

RE: LAURENCE A. BRIDGES, 1730 17TH ST. N.W., WASHINGTON, D.C. 20036

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

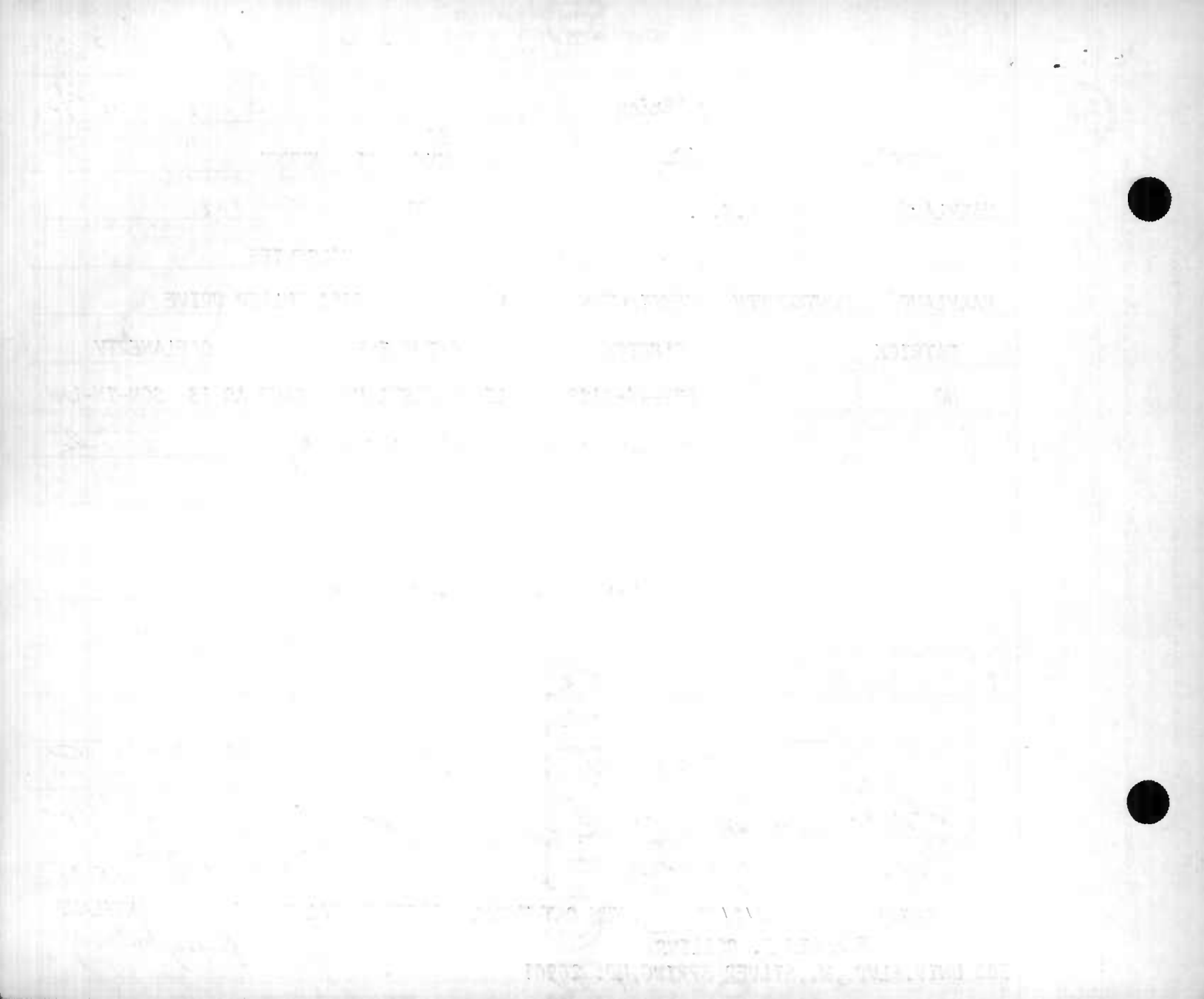
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>HELEN O'Brien BRILEY</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>3 29 80</u>			2b. HOUR <u>4:20 P.M.</u>				
3 SEX <u>Female</u>		4 RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>7 14 88</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>91</u> XXX YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY</u> MD.				
10. CITY OR TOWN OF DEATH <u>SILVER SPRING</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>HOLY CROSS HOSP.</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>HOUSEWIFE</u>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MARYLAND</u>			13b. COUNTY <u>MONTGOMERY</u>		13c. CITY OR TOWN <u>KENSINGTON</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>4412 PULLER DRIVE</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>PATRICK O'BRIEN</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>CATHERINE O'FLAHERTY</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>			16b. SOCIAL SECURITY NO. <u>579-44-8129</u>		17. INFORMANT ADDRESS <u>OLIVER EASTLAND SAME AS 13 SON-IN-LAW</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>FULMINANT PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic Lymphocytic Leukemia</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>3/15 to 80</u> to <u>3/29 1980</u> , that (I) (we) last saw the deceased alive on <u>3/29 1980</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										
22b. SIGNATURE <u>Barry N. Rosenbaum, M.D.</u>			DEGREE			22c. DATE SIGNED <u>3/29/80</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BARRY N. ROSENBAUM</u>			22e. ADDRESS <u>3720 FARRAGUT AVE. KENSINGTON, MD. 20795</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b. DATE <u>4/1/80</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL CEMETERY</u>		23d. LOCATION CITY OR TOWN COUNTY <u>BALTIMORE MARYLAND</u>			
24. FUNERAL DIRECTOR NAME <u>FRANCIS J. COLLINS</u>						25a. DATE REC'D. BY REGISTRAR <u>APR 3 1980</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901										



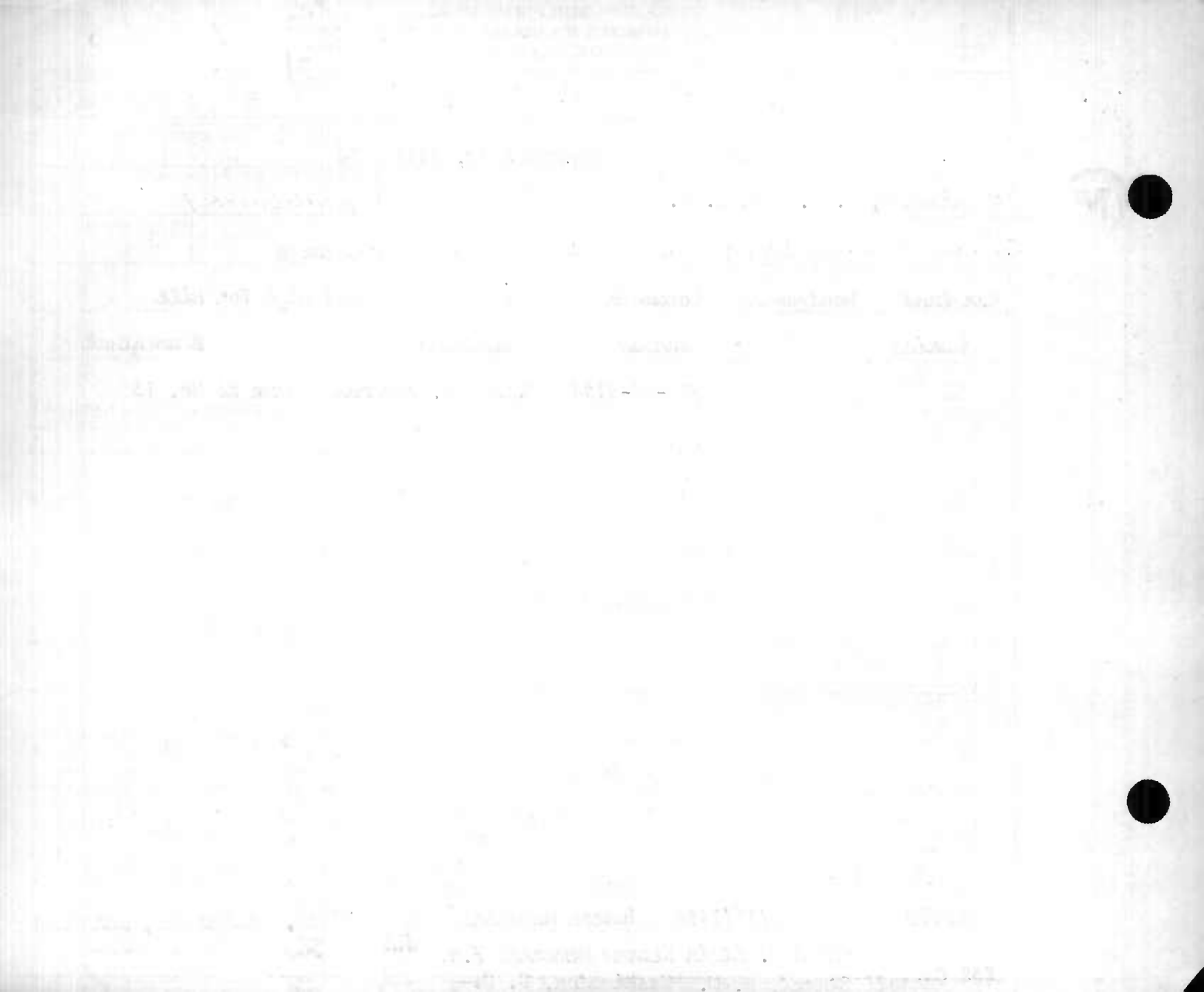
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the attending physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR		REG. NO. 0 0 7 7 3 6									
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
Linda E. Brotman								3 15 80		3:05 PM	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Female		White		December 30, 1941		38 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Washington, D. C.		U. S. A.				MONTGOMERY MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
SILVER SPRING		HOLY CROSS HOSPITAL						Housewife			
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS			
Maryland		Montgomery		Columbia				5641 High Tor Hill			
14 FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Maurice Warsaw		Beatrice Blumenthal									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT		ADDRESS					
No		579-54-3184		Ronald L. Brotman		Same as No. 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Coronary</u>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>5/10</u> 19 <u>80</u> , to <u>3/15</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>3/15</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED			
<u>Frederic T. Schwartz</u>		MD						15 March 80			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS									
Frederic T. Schwartz MD		5454 Wisconsin Ave. Chevy Chase Md.									
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		3/17/1980		Judean Memorial Gardens		Olney, Maryland		Montgomery		Maryland	
24 FUNERAL DIRECTOR NAME		24b ADDRESS		25a DATE RECD. BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
Donald M. Stein Hebrew Memorial F.H.		232 Carroll Street, N. W. Washington, D. C.		MAR 19 1980							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
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(VR A15 ME (5))
15M 7/76

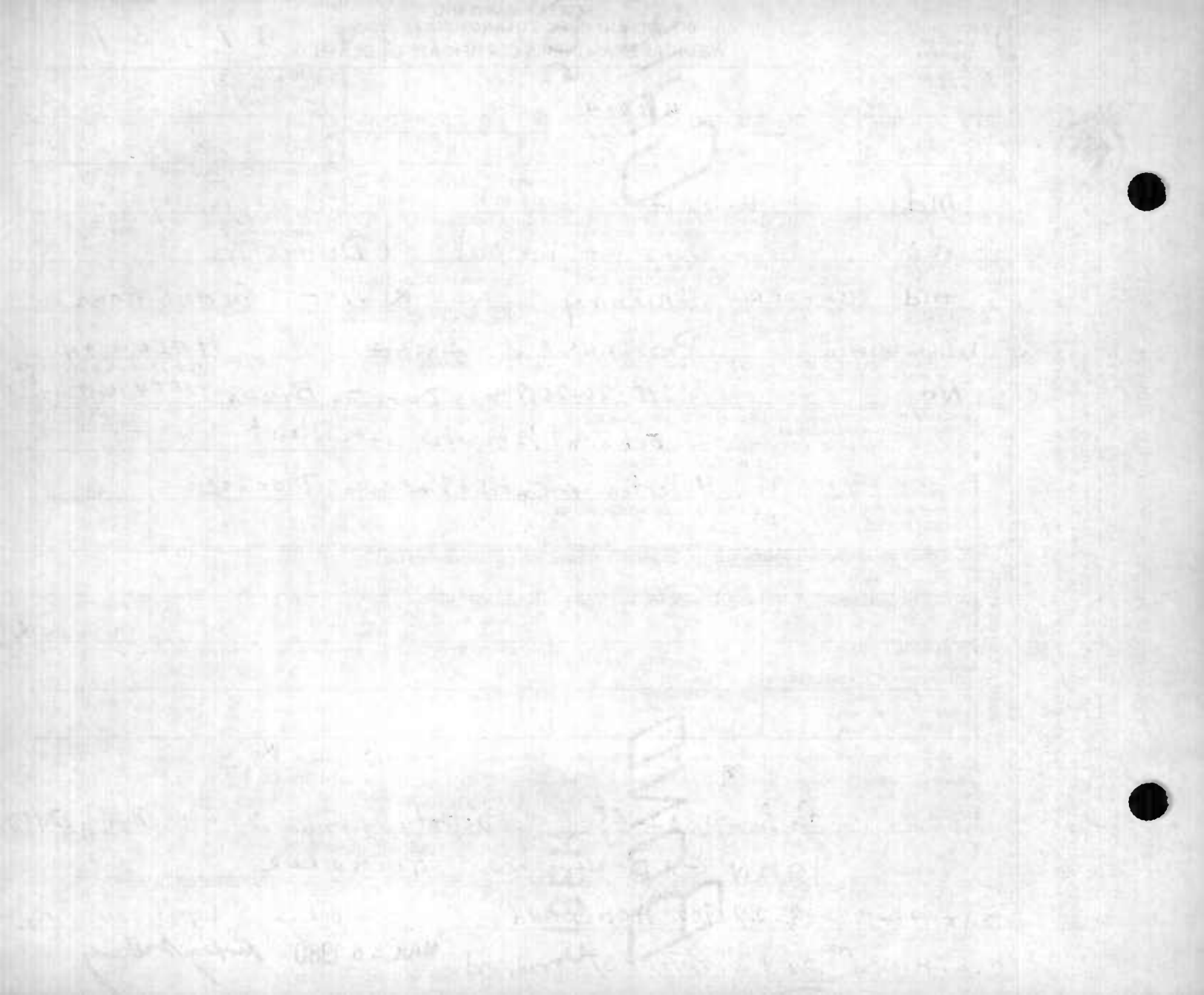
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07737
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		2b. HOUR					
Bessie		Luvexia		Brown				03 22 1980		8		PM				8 PM					
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR					
F	N	10 19 03		76		YRS.				03 22 1980		8		PM							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH															
Md		U.S.A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery Co.															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Rockville		Shady Grove Adv. Hospital		Domestic																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
Md		CARROLL		MT Airy		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4100 TWIN ARCH ROAD													
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																			
WILLIAM		BOWENS		LULA		HALLMAN															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS															
NO		215-26-2019		Mrs Dorothy Brown		Gaiherburg, Md. 1004 West Side															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 4029 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <u>Hypertensive Cardio Vascular Disease</u> (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?									
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN				COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE				John S. Bell				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED March 22, 1980					
EXAMINER'S NAME (TYPE OR PRINT)				John G. Bell				ADDRESS				Rockville									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN				COUNTY				STATE	
Burial				3-27-1980				Hopeland				Hopokita				Frederick				Md	
24. FUNERAL DIRECTOR NAME				C. E. Hick				ADDRESS				263 W. Patrick St				Fred, Md					

MAR 26 1980



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

07138

1. DECEASED NAME (TYPE OR PRINT) GRACE BROWN			2a. DATE OF DEATH MONTH 3 DAY 24 YEAR 1980			2b. HOUR 5P M			
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH July DAY 4 YEAR 1895		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING FAIRLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE MD		13b. COUNTY PG		13c. CITY OR TOWN LAUREL		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 400 MONTGOMERY ST	
14. FATHER'S NAME FIRST WILLIAM MIDDLE A LAST CROWTHER			15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE C. LAST WARE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 4140		17. INFORMANT ADDRESS 14410 BROWN RD HAROLD E. CROWTHER WANTS MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days years years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Cerebrovascular Disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from FEB 19 80 to MAR 24 80 , that (I) (we) lost saw the deceased alive on 3/14 19 80 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (If "we" (did not) view the body after death.									
22b. SIGNATURE Thos 6. Ward MD		22c. PHYSICIAN'S NAME (TYPE OR PRINT) Thos 6. WARD		22d. ADDRESS 6116 ROBINWOOD RD Bethesda, MD 20814		22e. DATE SIGNED 3/24/80		22f. DATE SIGNED 3/24/80	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION MAR. 25 1980		23b. DATE WESTVIEW MEM		23c. NAME OF CEMETERY OR CREMATORY CATONS VILLE MD		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME DANALDSON FUNERAL HOME		ADDRESS LAUREL MD		25a. DATE REC'D. BY REGISTRAR APR 2 1980		25b. REGISTRAR'S SIGNATURE Anthony McCreedy			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant on page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 07739	
1. FOR STATE REGISTRAR Lillian E. Brown						2a. DATE OF DEATH MONTH DAY YEAR March 15, 1980		2b. HOUR 1:46am			
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR DEC. 28 1904		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED TEACHER		12b. KIND OF BUSINESS OR INDUSTRY HIGH SCHOOL			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MARYLAND						13c. CITY OR TOWN MONTGOMERY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM TREW BROWN						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH GRIFFITH ENGLAND					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219-36-7527		17. INFORMANT ADDRESS EVELYN B. DAVIS (SAME AS 13e)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe pneumonia 586 - DUE TO, OR AS A CONSEQUENCE OF (b) Urinary & frequent septicaemic episodes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 days Many months											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Prolonged Dialysis, Tracheal intubation											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from June 19 78 , to 15 March 19 80 , that (I) (we) lost the saw the deceased alive on 15 Mar 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Gustavo S. Belaval, MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 15 Mar 80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GUSTAVO S. BELAVAL						22e. ADDRESS Leisure World Medical Center Silver Spring, Md 20906					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-18-80		23c. NAME OF CEMETERY OR CREMATORY CHESTER CEMETERY		23d. LOCATION CITY OR TOWN CHESTERTOWN		COUNTY STATE MARYLAND			
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES P/A						ADDRESS ROCKVILLE MD.		DATE REC'D. BY REGISTRAR 25. REGISTRAR'S SIGNATURE MAR 24 1980 <i>Jeffrey McBrady</i>			

BP

UNITED STATES

DEPARTMENT OF COMMERCE

BUREAU OF COMMERCE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO. 07740					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Louise Hines Brown					2a. DATE OF DEATH MONTH DAY YEAR March 31, 1980			2b. HOUR 2:45p		
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Jan. 31 1890		6. AGE (IN YEARS LAST BIRTHDAY) 90		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Pre Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY at home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Montg.		13c. CITY OR TOWN Sil. Spg.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Stephen Henry Hines					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Jane Dunston					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 677-12-5892		17. INFORMANT ADDRESS W.R. Frank Hines 11812-New Hampshire Ave Silver Spring, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH month										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR Sept 19 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from Sept 19 79 to March 31 19 80 , that (I) (we) last saw the deceased alive on March 31 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)										
22b. SIGNATURE OF PHYSICIAN R. W. Benack				DEGREE M.D.			22c. DATE SIGNED 3/31/80		22d. ADDRESS 4115 Colie Drive, Wheaton	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 3 1980		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.				
24. FUNERAL DIRECTOR NAME W.R. Frank Hines		ADDRESS 11812 New Hampshire Ave Sil. Sp. Md.		DATE REC'D. BY REGISTRAR APR 1 1980		25. REGISTRAR'S SIGNATURE Richard J. [Signature]				

SECRET
U.S. GOVERNMENT PRINTING OFFICE: 1980

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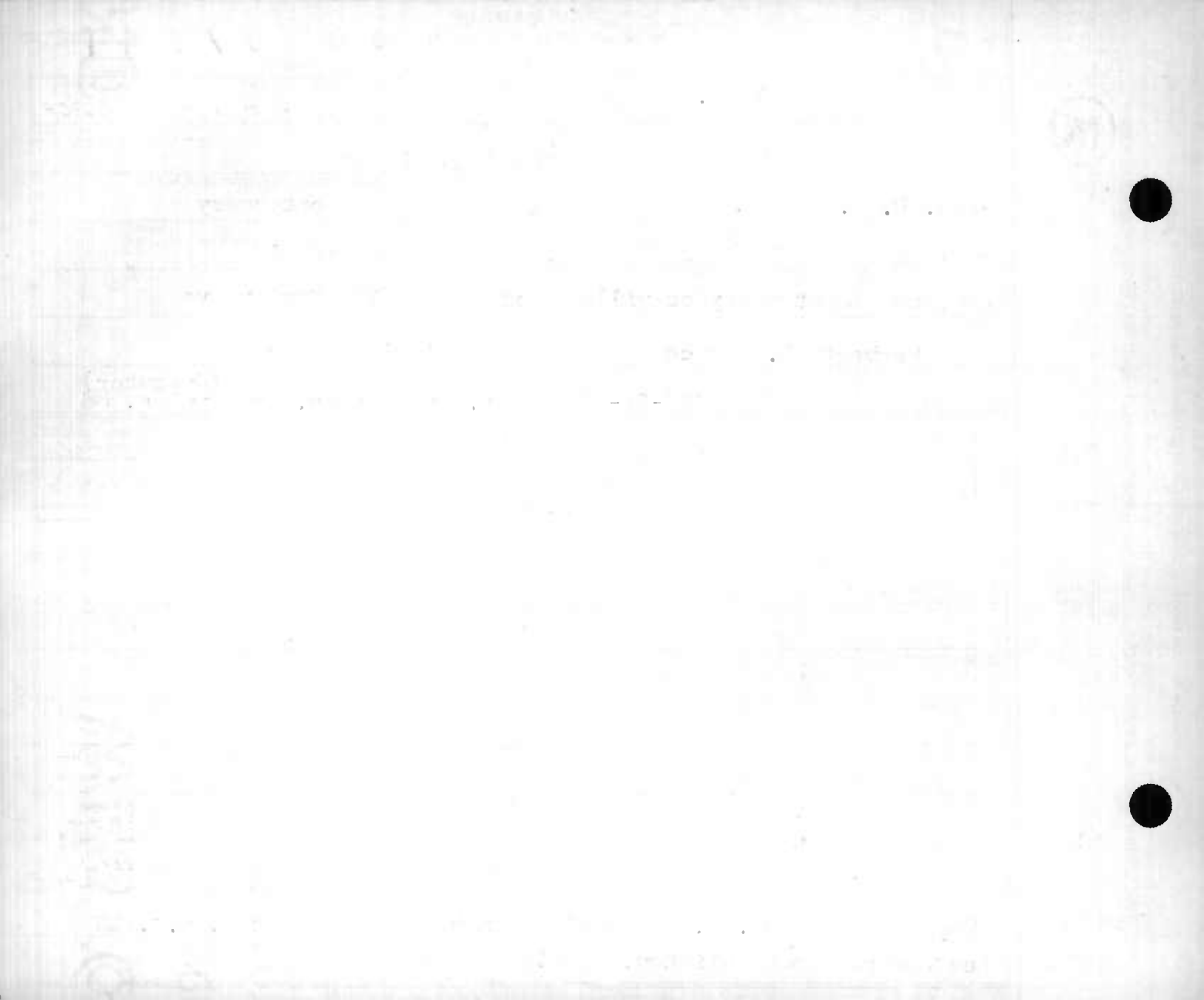
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 0 0 7 7 4 1				
1. DECEASED NAME (TYPE OR PRINT) MARY R. BROWN					2a. DATE OF DEATH MONTH DAY YEAR March 8, 1980			2b. HOUR 0230 AM	
3. SEX F		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR August 16, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D. C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Household		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. COUNTY Montgomery 13d. CITY OR TOWN Rockville					13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS 299 Hurley Ave		
14. FATHER'S NAME FIRST MIDDLE LAST Herbert L. Royce					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Uphoff				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-36-9524		17. INFORMANT ADDRESS (Executor) Mrs. Lynn Beyer, Brandywine, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiac arrest									1 minute
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (b) coronary atherosclerosis, cerebrovascular insufficiency									4 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) senile dementia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 10, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/9/78 , 19____, to present , 19____, that (I) (we) (lost) saw the deceased alive on 2/7/80 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert Millman		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/8/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Millman, MD				22e. ADDRESS 15 Deer Park Dr Gaithersburg Md 20878					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE Mar. 11, 80		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Clinton, Maryland				25a. DATE REC'D. BY REGISTRAR MAR 11 1980		25b. REGISTRAR'S SIGNATURE Robert McCreedy			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2602

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <i>Nellie Buchalter</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>3-14-80</i>			2b. HOUR <i>11:45 AM</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>8-30-93</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>86</i> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Russia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.			
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY -----	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>8484 - 16th Street</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Mordecai ----- Kite</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>(unknown)</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>218-54-8050J1</i>		17. INFORMANT ADDRESS <i>Chevy Chase, Md.</i> <i>Esther Collegeman; 2308 Washington Avenue</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>SEPSIS, GENERALIZED</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
5902 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>RIGHT RENAL ABSCESS</i>								3 weeks	
(c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>RENAL FAILURE, DIABETES MELLITUS, CONGESTIVE HEART FAILURE</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>2/27</i> 19 <i>80</i> , to <i>3/14</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>3/13</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <i>Robert L. Rosenberg</i>					DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3/14/80</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ROBERT L. ROSENBERG, MD</i>					22e. ADDRESS <i>6121 MONTROSE RD, ROCKVILLE, MD. 20852</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Mar 16, 1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>National Mem. Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Falls Church, Virginia</i>		
24. FUNERAL DIRECTOR NAME <i>DANZANSKY GOLDBERG</i>					ADDRESS <i>1170 ROCKVILLE PARK</i>		25a. DATE RECEIVED BY REGISTRAR <i>MAR 16 1980</i>		25b. REGISTERED <i>Robert L. Rosenberg</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 07743	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Marcella Burdette							2a. DATE OF DEATH MONTH DAY YEAR 03 02 80		2b. HOUR 1:25p		
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Aug. 8, 1885		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Never Worked		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. STATE Maryland			13b. COUNTY Mont.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8911 Watkins Road		
14. FATHER'S NAME FIRST MIDDLE LAST Richard Thomas Burdette					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura - Lewis						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 215-54-5025		17. INFORMANT Orin Burdette			ADDRESS Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction 410- DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 10 dgs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from Feb 19, 1980 to 2 March 1980 , that (1) (we) lost saw the deceased if March 1980 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did/did not) view the body after death.											
22b. SIGNATURE Lewis Kellert, MD				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/2/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis Kellert, MD				22e. ADDRESS 18111 Prince Phillip Dr. Olney, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE March 4, 1980		23c. NAME OF CEMETERY OR CREMATORY Boys		23d. LOCATION Boys Mont. COUNTY Md. STATE			
24. FUNERAL DIRECTOR NAME Francis H. Barber						ADDRESS Laytonsville, Md. 20760		25a. DATE REC'D. BY REGISTRAR MAR 5 1980		25b. REGISTRAR'S SIGNATURE Anthony McBrady	

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										0 7 7 4 4 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) John David Burke										2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> 3-21, 1980		2b. HOUR 5 PM	
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 4-12-1952		6. AGE (IN YEARS) LAST BIRTHDAY DAY YRS. 27		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 3-21, 1980		2d. HOUR 5 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Chevy Chase				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3307 Woodbine Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student				12b. KIND OF BUSINESS OR INDUSTRY Law	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3307 Woodbine Street			
14. FATHER'S NAME FIRST MIDDLE LAST Frederic Gerard Burke						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Elizabeth Deruin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No						16b. SOCIAL SECURITY NO. 214-52-4256		17. INFORMANT ADDRESS Frederic G. Burke 3307 Woodbine St. Chevy Chase, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Metastatic Angiosarcoma DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) Deputy				DATE SIGNED March 23, 1980					
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D.				ADDRESS 7936 Old Georgetown Rd.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Mar. 24, 1980		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Montg, Md.					
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR MAR 28 1980		25b. REGISTRAR'S SIGNATURE Pietro M. C...							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The certificate should be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
FOR STATE REGISTRAR				REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Anna E Byrnes				2a. DATE OF DEATH MONTH DAY YEAR Mar 18 - 88				2b. HOUR 11:55 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 27 1885		6. AGE (IN YEARS LAST BIRTHDAY) 94		7. IF UNDER 1 YEAR MONTHS DAYS YRS.		7. IF UNDER 24 HRS HOURS MIN YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8335 Grubb Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY G.P.O.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8335 Grubb Road	
14. FATHER'S NAME FIRST MIDDLE LAST Peter Byrnes				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie McCormick							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 164-09-4127		17. INFORMANT ADDRESS Washington, D.C. Therese O. Schneider, Niece. 3350 Tennyson					
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction APPROXIMATE INTERVAL IN DAYS 3 days 410- DUE TO, OR AS A CONSEQUENCE OF (b) Chronic arteriosclerotic heart disease 10 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a: Cardiomegaly - Cardiac arrhythmia.											
19a. DATE OF OPERATION ____		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ____				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) ____							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) ____		21f. LOCATION STREET CITY OR TOWN COUNTY STATE ____							
22. I certify that (I) (this hospital) attended the deceased from Jan 3 - 17 , 19 88 , to Mar 18 , 19 88 , that (I) (we) last saw the deceased alive on 3-17 , 19 88 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Thomas F. McMahon MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED 3-18-88			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas F. McMahon				22e. ADDRESS 2737 Devonshire Pl. N.W. Washington, D.C. 20008							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/20/1980		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland.			
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. 5130 Wisconsin Ave., N.W. Washington, D.C.				25a. DATE REC'D. BY REGISTRAR MAR 21 1988				25b. REGISTRAR'S SIGNATURE [Signature]			

10-10-68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

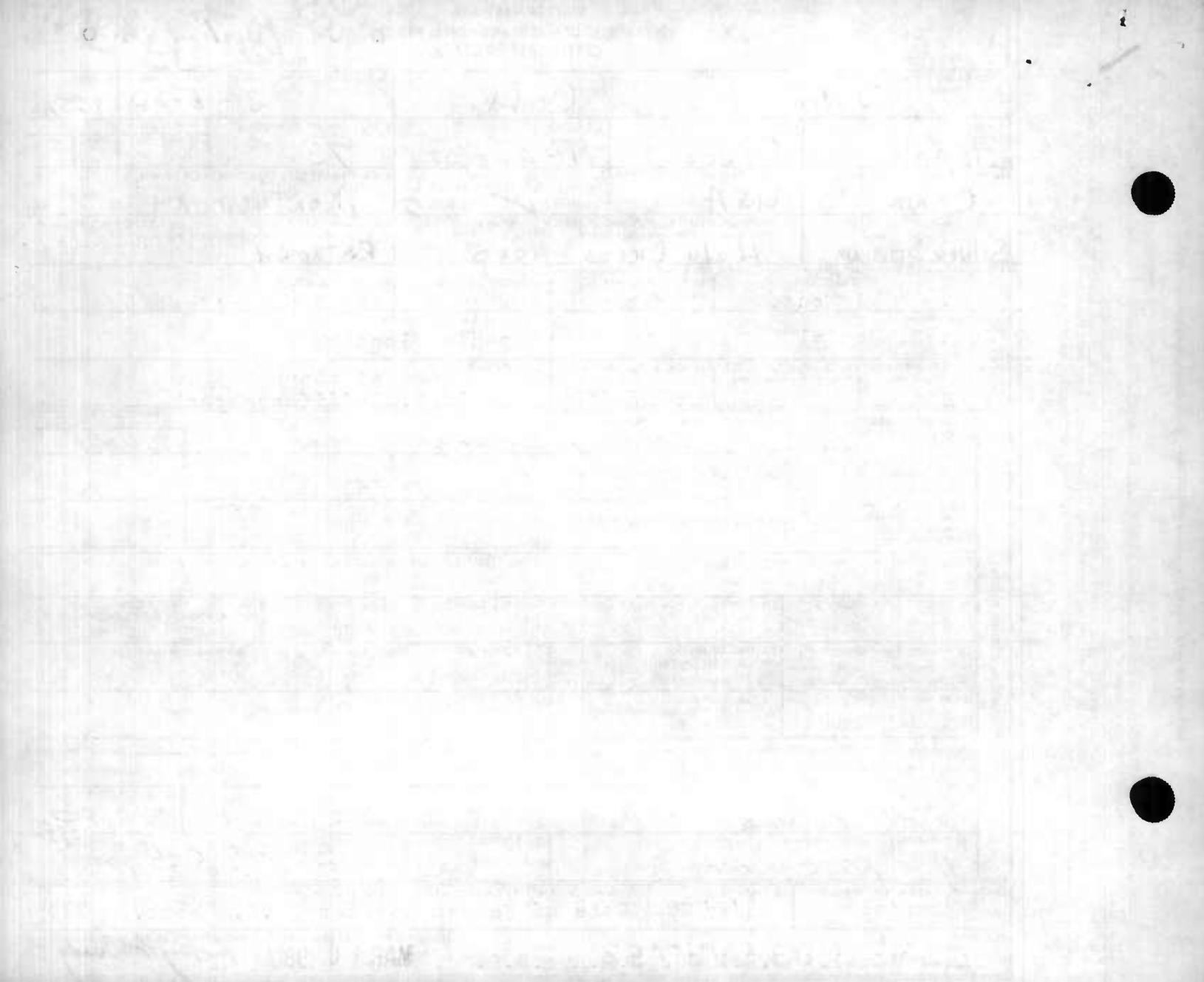
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Julia			FIRST Julia MIDDLE LAST Caffi			2a DATE OF DEATH MONTH DAY YEAR 3-5-80			2b HOUR 925AM		
3 SEX Female			4 RACE Caucas			5 DATE OF BIRTH MONTH DAY YEAR 1-26-07			6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) CONN			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10 CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b KIND OF BUSINESS OR INDUSTRY Housewife		
13a STATE Md.			13b COUNTY Mont.			13c CITY OR TOWN Wheaton			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME John S. Koziol			15 MOTHER'S MAIDEN NAME Sophie Oleaczyk			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None			16b SOCIAL SECURITY NO. 578 05 8518D		
17 INFORMANT Same as above			18 ADDRESS Angela S. Caffi (Daughter)			19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED		
20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3/5 19 80 P.M.		
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from 3/5 19 80 to 3/5 19 80 , that (I) (we) last saw the deceased alive on 3/5 19 80 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			22b SIGNATURE B. N. ROSENBAUM, M.D.			22c DATE SIGNED 3/5/80			22d PHYSICIAN'S NAME (TYPE OR PRINT) B. N. ROSENBAUM		
22e ADDRESS 3720 FARRAGUT AVE KENSINGTON, MD 20795			23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 3/8/80			23c NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery S.S. Mont. Md.		
23d LOCATION CITY OR TOWN COUNTY STATE			24 FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.11800 N.H.Ave.S.S.Md.			25a DATE REC'D. BY REGISTRAR MAR 10 1980			25b REGISTRAR'S SIGNATURE John J. McCreedy		



BP
DHMH-17
(VR A15 ME (5))
30M 7/73

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										07747 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Edward Joseph Raffney										2a. DATE KNOWN OF DEATH ESTIMATED March 2, 1980										2b. HOUR 1:15 PM	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Sept. 13 1943		6. AGE (IN YEARS) LAST BIRTHDAY 36 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD March 2, 1980		7d. HOUR 1:15 PM							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.									
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 107 Belton Rd				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Special Agent				12b. KIND OF BUSINESS OR INDUSTRY U.S. Treas.									
13a. STATE Md				13b. COUNTY Mont		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 107 Belton Rd											
14. FATHER'S NAME FIRST MIDDLE LAST John T. Gaffney						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Davey															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 215-36-5377		17. INFORMANT Mary L. Gaffney				ADDRESS Same as #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> 4391 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None																					
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE John S. Rogers										TITLE (SPECIFY) M.D. Dep.		MEDICAL EXAMINER		DATE SIGNED March 2, 1980							
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers										ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE Mar. 3, 1980		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Va.											
24. FUNERAL DIRECTOR NAME Francis J. Collins										ADDRESS 500 University Blvd. W., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR MAR 4 1980		25b. REGISTRAR'S SIGNATURE [Signature]							

3210

Handwritten notes at the top of the page, including the word "Special Agent" and other illegible text.

John T. Collins
115 55-2817
John T. Collins
115 55-2817

Large section of handwritten notes in the middle of the page, mostly illegible.

Handwritten notes at the bottom of the page, including the word "Continued" and other illegible text.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

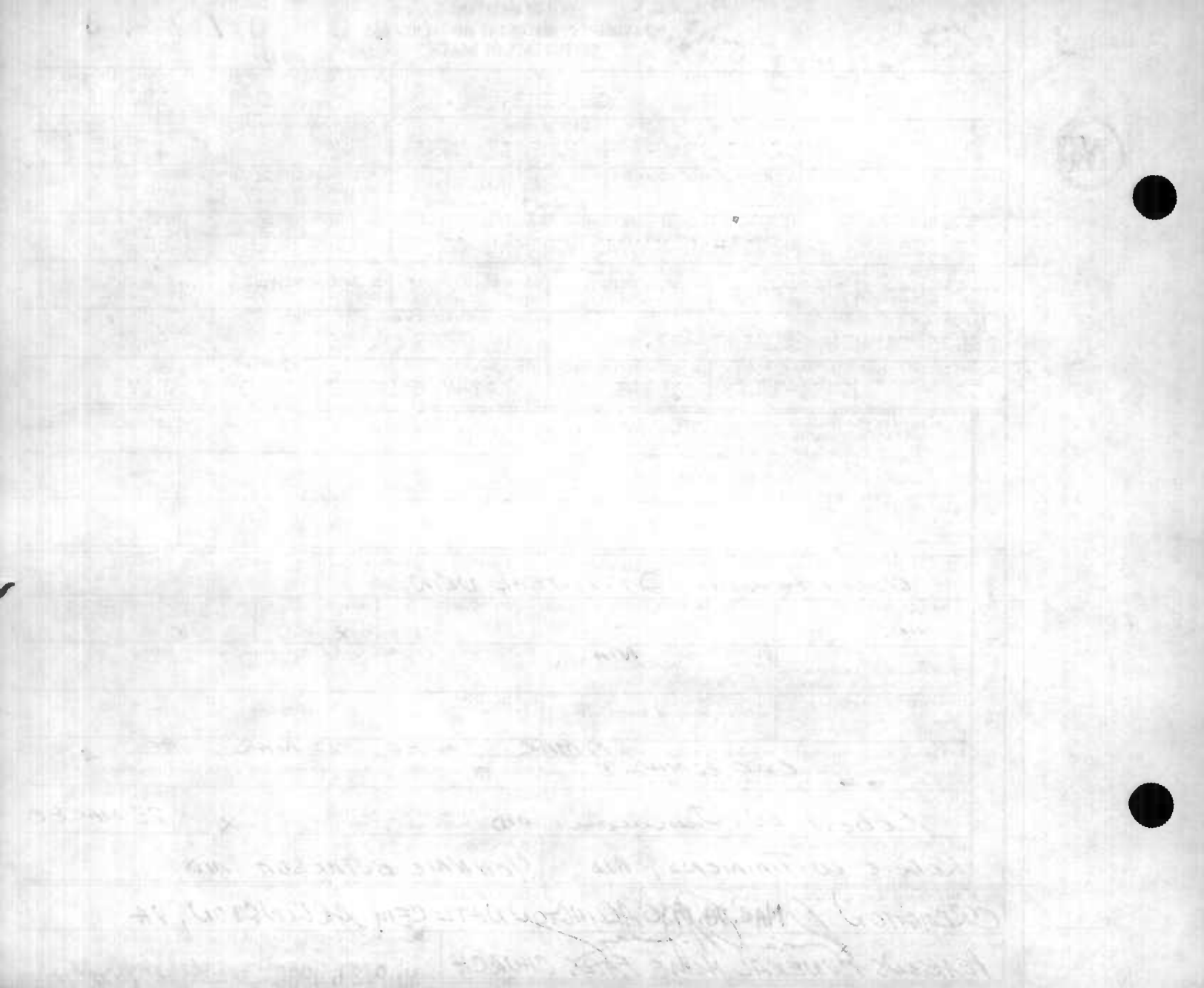
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DELOS SAMUEL CALKINS, JR.			2a. DATE OF DEATH MONTH DAY YEAR MAR 22 1980		2b. HOUR 0500A M
3 SEX MALE	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR JUNE 10 1935	6 AGE (IN YEARS LAST BIRTHDAY) 44 YRS	# UNDER 1 YEAR MONTHS DAYS	# UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD		
10 CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER	12b. KIND OF BUSINESS OR INDUSTRY EE & G	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VIRGINIA 13b. COUNTY FAIRFAX 13c. CITY OR TOWN FAIRFAX			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 5212 PORTSMOUTH ROAD	
14 FATHER'S NAME FIRST MIDDLE LAST DELOS SAMUEL CALKINS, SR.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HARRIET {NMN} STONE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAS OLD PAGES) 1958-1980 081326133	17 INFORMANT ADDRESS DOROTHY CALKINS SAME AS ABOVE			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MASSIVE PULMONARY EMBOLUS 4538 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). ORIGIN EMBOLUS - @ POPULTEAL VEIN					
19a. DATE OF OPERATION NO.	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 MAR , 19 80 , to 22 MAR , 19 80 , that (we) last saw the deceased alive on 22 MAR 1980 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Robert W. Timmons	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 23 MAR 80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Timmons, MD		22e. ADDRESS 60NNAL BETHESDA MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE MAR 24 1980	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATL CEM	23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON, VA		
24 FUNERAL DIRECTOR NAME ADDRESS PEARSON'S FUNERAL HOME FAIR CHURCH		25 DATE REC'D BY REGISTRAR MAR 26 1980	25b. REGISTRAR'S SIGNATURE Robert W. Timmons		



Item #16b Film 6544 6/4/80 rc

07749

FOR
1- STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Esther			MIDDLE J			LAST Carey			2a. DATE KNOWN OF DEATH MATED			MONTH 3			DAY 22			YEAR 1980			2b. HOUR 7:12 PM					
3 SEX Female			4 RACE Black			5. DATE OF BIRTH MONTH 3			DAY 3			YEAR 1980			6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.			IF UNDER 1 YR. MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.			7c. DATE PRONOUNCED DEAD 3/22/80			7d. HOUR 7:12 PM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina						7b. CITIZEN OF WHAT COUNTRY? U. S. A.						8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.											
10. CITY OR TOWN OF DEATH Silver Spring						11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital of Silver Spr						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk (Retired)						12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland												13b. COUNTY Montgomery			13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 2205 Westview Drive								
14. FATHER'S NAME FIRST Walter						MIDDLE			LAST Johnson			15. MOTHER'S MAIDEN NAME FIRST Lucinda						MIDDLE			LAST Kiser								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No						16b. SOCIAL SECURITY NO. 577-22-5826 577-05-6392						17. INFORMANT husband, Nathan Carey						ADDRESS SAA											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> 4291 (b) <u>Chronic Myocardial Dis.</u> (c) <u></u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>None</u>																													
19a. DATE OF OPERATION <u>None</u>						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE																	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																													
ACTUAL SIGNATURE <u>John S. Rogers</u>						TITLE (SPECIFY) M.D. <u>Dep.</u>						DATE SIGNED <u>March 22 1980</u>																	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers						ADDRESS 1919 Seminary Rd., Sil. Sprg., Md.																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 3/27/80						23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.						23d. LOCATION CITY OR TOWN Silver Spring, Maryland											
24. FUNERAL DIRECTOR NAME McGuire Funeral Ser. 7400 Ga. Ave., N.W.						APR 2 1980																							

Requiem Funeral for. JACKSON, Mrs. J.

Guests 7:30

John S. Rogers

John S. Rogers

John S. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

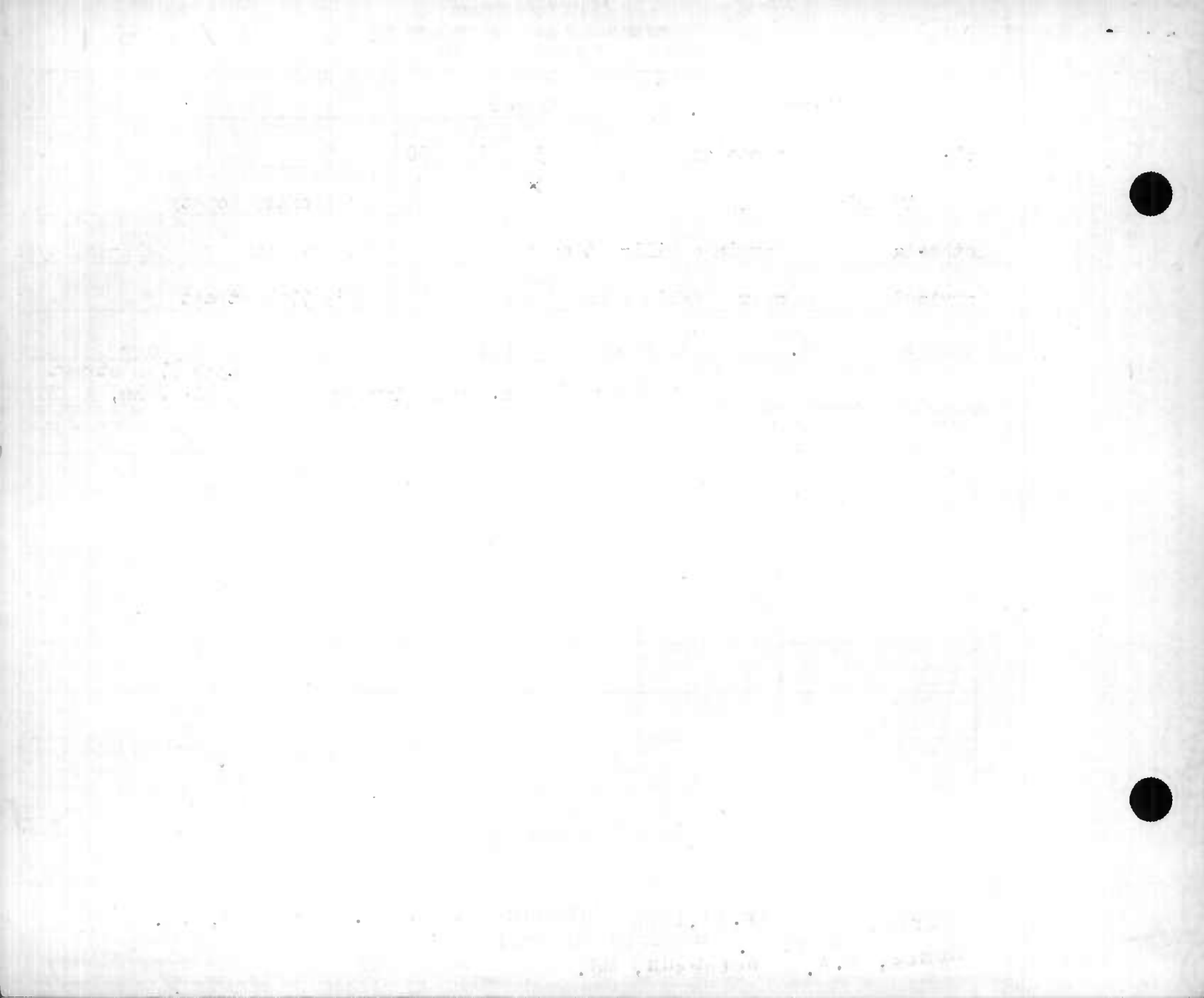
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 0 0 7 7 5 0	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CAROLINE O. CARPENTER						2a. DATE OF DEATH MONTH DAY YEAR MARCH 4, 1980		2b. HOUR 6:14 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 5 1894		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rockville Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C.				13b. COUNTY Washington		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 4707 Conn. Ave., N.W.			
14. FATHER'S NAME FIRST MIDDLE LAST Samuel C. Markland				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Ewell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-03-7935		17. INFORMANT Niece ADDRESS Jane G Jones, 5912 --36th Ave., Hyattsville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Pneumatic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) 3989 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from August 1979 to March 4 1980 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on Feb 28 1980 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE Patricia D Kellogg				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/4/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patricia D. Kellogg, M.D.				22e. ADDRESS 809 Viers Mill Rd. Rockville, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3/7/1980		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland.			
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. NAME ADDRESS 5130 Wisc. Ave., N.W. Wash., D.C.						25a. DATE REC'D. BY REGISTRAR MAR 7 1980		25b. REGISTRAR'S SIGNATURE Robert McBrady			

TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 0 07751	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wilbur M. Carper			2a. DATE OF DEATH MONTH DAY YEAR MARCH 17, '80			2b. HOUR 320 AM					
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 5 15 90		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill-Bethesda				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Storekeeper		12b. KIND OF BUSINESS OR INDUSTRY Self-Employed			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Cabin John		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6519 77th Street		
14. FATHER'S NAME FIRST MIDDLE LAST James M. Carper			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Fogg								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-40-0006		17. INFORMANT ADDRESS 6519 77th Street Cabin John, MD 20731 Mrs. Irene Carper						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1520 <i>Gastrointestinal Bleeding</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of duodenum</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i>5 yrs</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Arteriosclerotic Cardiovascular Disease</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3-12-80</u> to <u>3-17-80</u> , that (I) (we) lost saw the deceased alive on <u>3-12-80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Stephen W. DePier, M.D.</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-17-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN W. DEPIER, M.D.						22e. ADDRESS 6719 WILSON LANE, BETHESDA, MD 20834					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar. 19, 1980		23c. NAME OF CEMETERY OR CREMATORY Potomac MethCh Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Potomac, Md.				
24. FUNERAL DIRECTOR Name Robert A. Pumphrey Address P.A. Bethesda, Md.						25a. DATE REC'D. BY REGISTRAR MAR 22 1980		25b. REGISTRAR'S SIGNATURE <i>Patricia McCurdy</i>			



Film G5424/15/80 18 & 22a dad
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07752
 REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTI-MATED		MONTH		DAY		YEAR		2b. HOUR			
John		XXX		N.		Cartney		JR.		3		9		19		80			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR			
Male		White		NOV 4, 1926		53 YRS.				3		9		19		80			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
PENNSYLVANIA				U.S.A.								Montgomery County, MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring				Holy Cross Hospital				INDEPENDENT TRUCKER											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. STATE				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS			
MARYLAND				MONTGOMERY				SILVER SPRING				YES				10620 LORAIN AVENUE			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
JOHN N. CARTNEY, SR.				MARIAN O'BRIEN															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS							
YES				WW II				198-16-2073				JANE P. CARTNEY SAME AS 13 WIFE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED											
Virginia L. Dolan MD				Assistant				3/10/80											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
Virginia L. Dolan, M.D.				111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
BURIAL				3/12/80				ST. JOHN'S				FOREST GLEN MONT MD.							
24. FUNERAL DIRECTOR												25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
FRANCIS J. COLLINS												MAR 17 1980		[Signature]					
300 UNIV. BLVD., W., SILVER SPRING, MD. 20901																			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

NOV 1 1960

NOV 1 1960

U.S.A.

INDEPENDENT RECORDS

STREET 2111

NEW YORK

D. STEIN

NEW YORK

CARTER, JIM

JOHN

NOV 11 1960 JAMES P. CARTER

RECEIVED

NOV 1 1960

NOV 1 1960

NOV 1 1960

NOV 1 1960

NOV 1 1960

MAR 1 1960

NOV 1 1960

DATE March 21 1982
SIGNED _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0 0 7 7 5 4				
1. FOR STATE REGISTRAR				2r. DATE OF DEATH MONTH DAY YEAR 03-09-80				2b. HOUR 7:20
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Stefano Castrogiovanni				3. SEX male				4. RACE white
5. DATE OF BIRTH MONTH DAY YEAR 07-13-47				6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS.				7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy
8. CITIZEN OF WHAT COUNTRY? USA				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD				10. CITY OR TOWN OF DEATH Silver Spring
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12r. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Musician				12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland				13b. COUNTY Montgomery				13c. CITY OR TOWN Rockville
14. FATHER'S NAME FIRST MIDDLE LAST Giuseppe Castrogiovanni				15. MOTHER'S MAIDEN NAME FIRST MIDDLE Anna Banhozzi				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) no
16b. SOCIAL SECURITY NO. 220 54 1162				17. INFORMANT ADDRESS Giuseppe Castrogiovanni same as 13c				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				303-
DUE TO, OR AS A CONSEQUENCE OF (b) HEPATIC FAILURE				24 HRS				DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC ALCOHOLISM
DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC ALCOHOLISM				YEARS				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) GASTROINTESTINAL BLEEDING, SEVERE & E. COLI SEPSIS & RENAL FAILURE								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from APPROXIMATELY 19 78 to 3/9 19 80, that (I) (we) lost saw the deceased alive on 3/8 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		
22b. SIGNATURE Arnold G. Levy MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-9-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arnold G. Levy, M.D.		22e. ADDRESS 1106 SPRING ST. SILVER SPRING, MD. 20910		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				
23b. DATE 3/12/80		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Md.		24. FUNERAL DIRECTOR'S NAME Dyson Wheeler Funeral Home, Inc.		
24. FUNERAL DIRECTOR'S ADDRESS 1331 Rockville Pike Rockville, Maryland 20852		25a. DATE REG'D. BY REGISTRAR 3/14/80		25b. REGISTRAR'S SIGNATURE				



USA

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Montgomery

Kushlan

Chicago

Centerville

Ann

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250 24 1105, Chicago Centerville Ann 110

1951 Knoxville Park Locustville, Maryland 21092
Tyson Hotel Centerville, Inc.
Huntel 3/15/80 Date of Heaven Cemetery Silver Spring, Md.

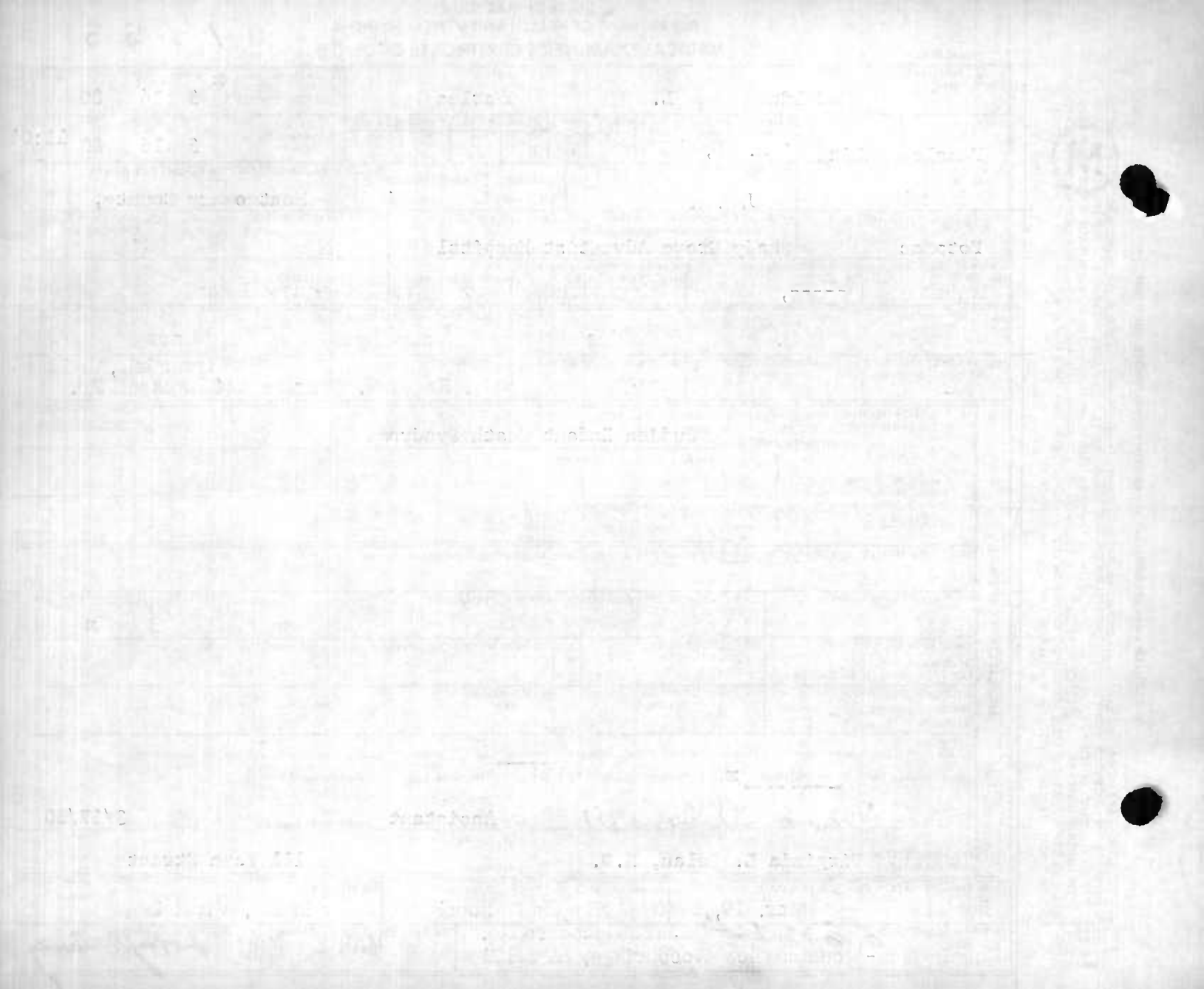
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 4 AND 5 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M/7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07755
REG. NO.

1- STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
Madelaine L. Charles		Female		White	
5. DATE OF BIRTH		6. AGE (IN YEARS)		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
Oct. 20, 1979		4 YRS. 23 MONTHS		Maryland	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
		Montgomery County, MD.		Potomac	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Shady Grove Adventist Hospital		N/A		N/A	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Virginia		Alexandria		Alexandria	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	
Roger G. Charles		Mary Lee Carr		NO	
16b. SOCIAL SECURITY NO.		17. INFORMANT		17a. ADDRESS	
N/A		Mr. Roger G. Charles		Alexandria, Va 22301	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18a. IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:		Sudden Infant Death Syndrome			
7980		DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		(b)			
		DUE TO, OR AS A CONSEQUENCE OF			
		(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Virginia L. Dolan		Assistant		3/17/80	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Virginia L. Dolan, M.D.		111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Mar. 19, 1980		Arlington National	
24. FUNERAL DIRECTOR NAME		24a. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
B. E. Mountcastle		13318 Occoquan Rd.		MAR 24 1980	
Cunningham-Mountcastle		Woodbridge, VA 22191		25b. REGISTRAR'S SIGNATURE	
				M. J. McCreedy	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 80 07756	
1. DECEASED NAME (TYPE OR PRINT) WILLIAM JOHN CHURA						2a. DATE OF DEATH MONTH DAY YEAR March 28, 1980			2b. HOUR 4:30 PM		
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR May 8, 1914		6 AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		10 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD					
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, Bethesda, Md				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plastics Engineer		12b. KIND OF BUSINESS OR INDUSTRY G.E.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY New York Tioga						13d. CITY OR TOWN Owego		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13f. STREET ADDRESS Route #1 Box 98	
14. FATHER'S NAME FIRST MIDDLE LAST John Chura						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alexandra Perry					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 077-05-4523		17 INFORMANT Mrs. Elizabeth Chura, wife		ADDRESS (same as above)					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GLIOBLASTOMA MULTIFORME 1919 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YRS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) BRONCHOPNEUMONIA											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (x) (this hospital) attended the deceased from February 14 19 80, to March 28 19 80, that (x) (we) last saw the deceased alive on March 28 19 80, and that in (x) (our) opinion death occurred on the date and hour and from the causes stated above. (we did (1) (2) (3) (4) view the body after death.											
22b. SIGNATURE Albert P. Galdi		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 3-28-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALBERT P. Galdi MD		22e. ADDRESS National Institutes of Health, Clinical Center, Bethesda, Md. 20205									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/31/80		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Russ. Orth. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Binghamton, NY					
24 FUNERAL DIRECTOR NAME Robert A. Humphrey Funeral Homes, P.A. Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR APR 2 1980		25b. REGISTRAR'S SIGNATURE Anthony McCreedy							



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) <u>Julia H CIESIA</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>March 23 1980</u>		2b. HOUR <u>12 P</u> M		
3. SEX <u>FEMALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>Feb 3 1914</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>66 1/2</u> YEARS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>ILKLAND PA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONTG CTY</u> MD.	
10. CITY OR TOWN OF DEATH <u>SILVERSPRING</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>HOLY CROSS</u>		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <u>AD. Gov. RETIRED</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>AD. Gov.</u>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <u>WASH DC</u>		13b. COUNTY <u>Dist DCOL</u>		13c. CITY OR TOWN <u>Dist DCOL</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>JOSEPH CIESIA</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>HELEN MARC</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>070-030-835</u>	
17. INFORMANT NAME ADDRESS <u>JOHN CIESIA 328 - N. McKinley Ave</u>		17. INFORMANT NAME ADDRESS <u>JOHN CIESIA 328 - N. McKinley Ave</u>		17. INFORMANT NAME ADDRESS <u>JOHN CIESIA 328 - N. McKinley Ave</u>		17. INFORMANT NAME ADDRESS <u>JOHN CIESIA 328 - N. McKinley Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST (b) <u>Pneumonia</u>						3 days	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Primary hepatoma of liver</u>						6 mos - 1 yr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):							
19a. DATE OF OPERATION <u>1/31/80</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Hepatoma of Liver</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/30</u> 19 <u>80</u> , to <u>3/23</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>3/23</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Steven Cristian</u>		DEGREE		22c. DATE SIGNED <u>3/24/80</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Steven CRISTIAN</u>		22e. ADDRESS <u>344 University Blvd W. Silver Spring Md.</u>		22f. DATE REC'D. BY REGISTRAR <u>MAR 27 1980</u>		22g. REGISTRAR'S SIGNATURE <u>Jeffrey McCreedy</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>26 MAR 80</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>JOHNSON CITY N.Y.</u>	
24. FUNERAL DIRECTOR NAME <u>Hines/Ronald</u>		ADDRESS <u>11800 N.H. Ave S.S. Md</u>		24. FUNERAL DIRECTOR NAME <u>Hines/Ronald</u>		ADDRESS <u>11800 N.H. Ave S.S. Md</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 80 07758			
1. DECEASED NAME (TYPE OR PRINT) EDNA May CLAXTON										2a. DATE OF DEATH MONTH 3 DAY 10 YEAR 80		2b. HOUR 1:50 P. M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 4 DAY 25 YEAR 06		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 		8. IF UNDER 24 HRS. HOURS MIN. 			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) Kensington Gardens				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 15537 Foxhall Drive	
14. FATHER'S NAME William N. Conley				15. MOTHER'S MAIDEN NAME Maude Nonnemaker									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 075 07 0582		17. INFORMANT F. Tom Claxton				17b. ADDRESS same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Severe arteriosclerotic cardiovascular disease													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 3720 FARRAGOT AVE		CITY OR TOWN KENSINGTON		COUNTY MD		STATE 20795			
22a. I certify that (I) (this hospital) attended the deceased from 3/10/80 to 3/10/80 , that (I) (we) last saw the deceased alive on 3/10/80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE B. N. ROSENBAUM				DEGREE				22c. DATE SIGNED 3/10/80		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. N. ROSENBAUM				22e. ADDRESS 3720 FARRAGOT AVE KENSINGTON, MD 20795									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/13/80		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery				23d. LOCATION CITY OR TOWN Silver Spring, Maryland		COUNTY STATE 			
24. FUNERAL DIRECTOR'S NAME Tyson Wheeler Funeral Home, Inc.				25. DATE REC'D. BY REGISTRAR MAR 14 1980				25b. REGISTRAR'S SIGNATURE Anthony McCreedy					
1331 Rockville Pike Rockville, Maryland 20852													

1971 Roosevelt and Roosevelt, National 1971
Tyson - member, United Home, Inc.
3/13/80 Date of Member Secretary: Oliver Spring, Maryland

no -- 025 05 0285 P. Tom Jaxton came on 130

William H.

College + Trade

Nonmember

Maryland Montgomery Silver Spring X 1971 Tom Hill Drive

Remington

Homestead

Non

USA

Montgomery

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Dorothy Cohen			2a. DATE OF DEATH MONTH DAY YEAR 3/16/80			2b. HOUR 11:05 P.M.			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR December 25, 1905		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D. C.			13b. COUNTY		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Abraham Kuperstein			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tillie Magazinic						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-30-7292		17 INFORMANT ADDRESS Samuel Cohen (Same as # 13)					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction, massive 410- DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease years DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from April 19 1969, to 3-16 19 80, that (I) (we) last saw the deceased alive on March 16 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature] DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JASON GEIGER, M.D.				22e. ADDRESS 8830 CAMERON STREET SILVER SPRING, MD. 20910					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/18/1980		23c. NAME OF CEMETERY OR CREMATORY SHEV SHOLOM TALMUD TORAH CONGREGATION		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON D. C.			
24 FUNERAL NAME DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D. C.				25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 4 1980 [Signature]					

B. C.

WASHINGTON

2/11/90
BUREAU
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C.

Samuel Cohen (Sme as # 13)

Texas

Washington

Albany

Washington

NY

D. C.

1327 Action Street, N. W.

Honorable

John Cross President

Robert Smith

U. S. A.

President

December 25, 1992

Wash.

President

74

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GILBERT A COLE			2a. DATE OF DEATH MONTH DAY YEAR 3 3 80			2b. HOUR 215 P.M.	
3. SEX M		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR 6 9 99		6. AGE (IN YEARS LAST BIRTHDAY) 80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingwood Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY DC Fireman	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland		13c. COUNTY Montgomery		13d. CITY OR TOWN Silver Spring		13e. STREET ADDRESS 14539 Kelman Scott Dr.,	
14. FATHER'S NAME FIRST MIDDLE LAST Frank H. Cole		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida E. Nelson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 1		17. INFORMANT (son) Gilbert A. Cole, Jr.		18. ADDRESS 1817 Brisbane St. Silver Spring, Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ventricular Arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Broncho pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bronchogenic Carcinoma</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 min 7 days 1 year.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Chronic obstructive Lung disease</u>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 26</u> , 19 <u>80</u> , to <u>March 3</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>March 2</u> , 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>James R. Moore Jr.</u>		DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c. DATE SIGNED 3-3-80
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James R. Moore Jr.		22e. ADDRESS 207 Brookes Ave Gaithersburg		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-5-1980		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Suitland pr. Georges Md.
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR MAR 6 1980		
24. FUNERAL DIRECTOR NAME Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.		25. REGISTER'S SIGNATURE H. J. McCreedy		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
I. DECEASED NAME (TYPE OR PRINT) Beatrice Irene Coulombe					2a. DATE OF DEATH MONTH DAY YEAR March 11, 1980			2b. HOUR 4:32P.M.	
3 SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR May 18, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md 13b. COUNTY Pro Georges 13c. CITY OR TOWN Bowie					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6901 Highbridge Road		
14. FATHER'S NAME FIRST MIDDLE LAST Phillip Gingras					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virdget St. Onge				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 578 22 2844		17. INFORMANT Raymond A Coulombe			ADDRESS Adelphi, Md.		
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiogenic shock</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY Yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Diabetes</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>19 76</u> to <u>11 Mar</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>11 Mar</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Robert T. Kelley</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3-12-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert T. Kelley, M.D.					22e. ADDRESS 8218 Wisconsin Ave. Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar 14, 1980		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pro Georges Md.		
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyatts. Md.					25a. DATE REC'D. BY REGISTRAR MAR 17 1980				

8 0 0 7 7 6 1

6. COLLEGE-LEVEL

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 07762	
1. DECEASED NAME (TYPE OR PRINT)		FIRST BYRON		MIDDLE B.		LAST COX		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7c. DATE PRONOUNCED DEAD		2b. HOUR	
Male		White		Dec. 25, 1922		57 YRS.		March 1, 1980		4 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		2d. HOUR	
Virginia		USA		WIDOWED		DIVORCED		Montgomery		11 AM	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Gaithersburg		407 W. Diamond St.		Ret. Military		Army					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Mont.		Gaithersburg		YES NO		407 W. Diamond Ave.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Walter William Cox		Mary Jane Harner		Yes		224-28-2511		Leona Callaway		Gaithersburg, Md. 20760	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> 4292 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Cardio Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Emphysema</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
										YES NO	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED					
		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2							
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE			
21g. INJURY OCCURRED WHILE AT WORK		21h. INJURY OCCURRED NOT WHILE AT WORK		21i. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21j. LOCATION		CITY OR TOWN		COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED							
John G. Ball		M.D. Deputy		March 2, 1980							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		DATE SIGNED							
John G. Ball		Bethesda, Md.		March 2, 1980							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		March 4, 1980		Laytonsville		Laytonsville Mont. Md. STATE					
24. FUNERAL DIRECTOR		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Francis H. Barber Laytonsville, Md. 20760		MAR 3 1980		Anthony McCreedy							



CHILLOW

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Effie Mae Cox			2a. DATE OF DEATH MONTH DAY YEAR March 20, 1980		2b. HOUR 6:05 P.M.						
3 SEX Female		4 RACE White		5. DATE OF BIRTH April 21, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 87		7. UNDER 1 YEAR MONTHS DAYS		7. UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Md.		13b. COUNTY P. G.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5409 Emerson St.			
14. FATHER'S NAME FIRST MIDDLE LAST Lee Chappell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Williams							
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. IF YES, GIVE WAR OR DATES		16c. SOCIAL SECURITY NO 213-74-1641		17. INFORMANT ADDRESS Bruce A. Cox College Park, Md.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 486. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) was MAK 20 attended the deceased from JAN 15 , 19 80 , to MAR 20 , 19 80 , that (I) was MAK 20 saw the deceased alive on MAK 20 , 19 80 , and that in (my) last opinion death occurred on the date and hour and from the causes stated above, (I) was MAK 20 (did not) view the body after death.							
22b. SIGNATURE Walter E. Goozh				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED MAR 21, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Walter E. Goozh				22e. ADDRESS 2309 Shorefield Rd., Wheaton, Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar 24, 1980		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pro Georges Md.	
24. FUNERAL DIRECTOR NAME F. Gasch's Sons P A				ADDRESS Hyattsville, Md.		25a. DATE RECD. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 26 1980 notary McBrady	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Francis A Cox			2a DATE OF DEATH MONTH DAY YEAR March - 28 - 80		2b HOUR 4:30 AM
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Aug. 1 22/18	6 AGE (IN YEARS LAST BIRTHDAY) 61 YRS	7 UNDER 1 YEAR MONTHS DAYS 8 UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
10 CITY OR TOWN OF DEATH Bethesda Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Home
13a STATE Maryland		13b COUNTY Montgomery	13c CITY OR TOWN Gaithersburg	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 7904 Spiceberry Circle
14 FATHER'S NAME FIRST MIDDLE LAST Thomas H. Follin		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie A. Auterback			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO 579-22-2145		17 INFORMANT ADDRESS Turner Kisner, Same as #13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of lungs 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Hypercalcemia					
19a DATE OF OPERATION None		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 19 79 to 3/27 , 19 80 , that (I) (we) lost saw the deceased alive on 3/27 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Joel Schelman		DEGREE		22c DATE SIGNED 3/28/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Joel Schelman		22e ADDRESS 9410 Old Georgetown Road			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 4-1-80	23c NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Bethesda Montgomery Md.
24 FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., Bethesda, Maryland			25a DATE REC'D. BY REGISTRAR APR 2 1980		25b REGISTRAR'S SIGNATURE Patrick McCready

Washington, D.C. U.S.A.

Department of State

Office of the Secretary of State

Mr. H. H. Hollis

370-11-1111 Turner Street, Suite 212

Washington, D.C.

Dear Mr. Hollis:

I am writing to you regarding the matter of the

recent visit of the Secretary of State to the

United States and the subsequent discussions

with the President and the Vice President.

I am sure that you will find the information

of interest and I am sure that you will find

it of great value.

I am sure that you will find it of great value.

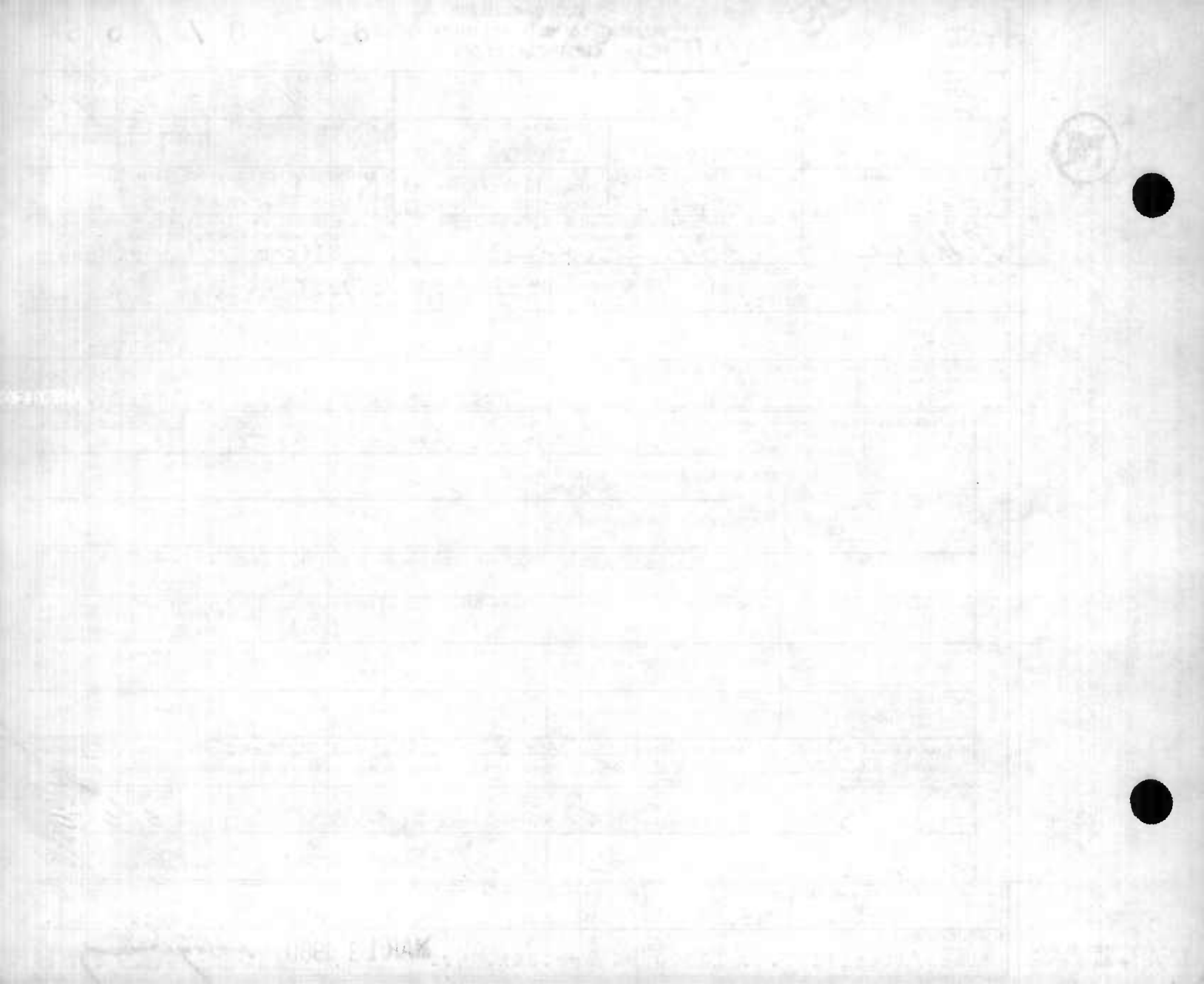
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 0 7 1 6 5	
FOR 1- STATE REGISTRAR					REG. NO.						
1 DECEASED NAME (TYPE OR PRINT) Theodosia Cox					2a. DATE OF DEATH MONTH DAY YEAR March 7 '80		2b. HOUR 9 A.M.				
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 11 26 1892		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Editor		12b. KIND OF BUSINESS OR INDUSTRY Amer. Museum			
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12613 Denley Rd., Wheaton, Md.			
14 FATHER'S NAME FIRST MIDDLE LAST John Cox					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amanda Keller						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 578-44-7522A		17 INFORMANT ADDRESS Gertrude Clark 12613 Denley Rd., Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 436- DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) None											
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET —		CITY OR TOWN —		COUNTY —		STATE —	
22a. I certify that (I) (this hospital) attended the deceased from 4/28 , 19 78 , to present , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
23a. SIGNATURE John B. Umhan MD					DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/6/80		
24a. PHYSICIAN'S NAME (TYPE OR PRINT) John B. Umhan MD					24b. ADDRESS 8805 Conn. Ave. Chevy Chase Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 10, 80		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN Rockville		COUNTY Mont.		STATE Md.	
24 FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.					ADDRESS 11800 NH Ave. Sil. Spr. Md.		25a. DATE REC'D. BY REGISTRAR MAR 11 1980		25b. REGISTRAR'S SIGNATURE John B. Umhan		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					REG. NO.	
1. FOR STATE REGISTRAR					8 0 0 7 1 6 6	
1. DECEASED NAME (TYPE OR PRINT) <u>Lois Marie Cranston</u>					2a. DATE OF DEATH MONTH DAY YEAR 3 17 80	
3 SEX <u>FEMALE</u>					2b. HOUR 11 P.M.	
4 RACE <u>WHITE</u>					6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
5. DATE OF BIRTH MONTH DAY YEAR JULY 11, 1912					8 IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>VIRGINIA</u>					9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY</u> MD.	
7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					12b. KIND OF BUSINESS OR INDUSTRY	
10. CITY OR TOWN OF DEATH <u>SILVER SPRING</u>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>HOUSEWIFE</u>	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>HOLY CROSS HOSPITAL</u>					12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <u>MARYLAND</u>					13b. STREET ADDRESS <u>3000 HARDY AVENUE</u>	
13c. CITY OR TOWN <u>SILVER SPRING</u>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>GROVER C. GODFREY</u>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE <u>MARY HEFLIN</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <u>NO</u>					16b. SOCIAL SECURITY NO. <u>577-09-0628</u>	
17. INFORMANT <u>DAUGHTER</u>					ADDRESS <u>P.O. BOX 84 DICKERSON, MD. 20751</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY ARTERIOSCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>DIABETES MELLITUS</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 YRS.</u> <u>7 YRS.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 1978</u> to <u>17 March, 1980</u> , that (I) (we) last saw the deceased alive on <u>17 March 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Eugene P. Libre</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>18 March 79</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>EUGENE P. LIBRE MD</u>		22e. ADDRESS <u>10400 Corn. Ave Kensington Md 20795</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>3/20/80</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>ARLINGTON VIRGINIA</u>
24. FUNERAL DIRECTOR <u>FRANCIS J. COLLINS</u>		ADDRESS <u>Collins Funeral Home 500 Dean Blvd Wt</u>		25a. DATE REC'D. BY REGISTRAR <u>MAR 21 1980</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

SUBAL
FRANCIS J. COLLINS
5/20/80
ARLINGTON NATIONAL

ARLINGTON

VIRGINIA

DAVID M. MELLER
8 X 4
7 X 2

577-09-0628
JOYCE LAMBE COLLIER
DAUGHTER
HARRY

P.O. BOX 14
DICKERSON, MD 21735

GROVER

C.

GOODREY

HARRY

HEFLIN

MARYLAND

MONTGOMERY SILVER SPRING

X

3000 HARDY AVENUE

SILVER SPRING

HOLY CROSS HOSPITAL

HOUNSNETT

VIRGINIA

U.S.A.

XX

MONTGOMERY

WHITE

JULY 11 1912

F. EMLE

WHITE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ETHEL V CUMMINGS		2a. DATE OF DEATH MONTH DAY YEAR 03 02 80		2b. HOUR 458 A M
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR 01 06 96		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10 CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN ROCKVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM HAGGERTY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE BARRETT		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-48-3506	17 INFORMANT ADDRESS JOHN I. CUMMINGS SAME AS 13 SON		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 1991 Adenocarcinoma, primary site unknown DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to Mar 2, 1980, that (I) (we) last saw the deceased alive on Mar 1, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Hubert J. Alpert		DEGREE M.D.		22c. DATE SIGNED Mar. 2, 1980
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUBERT J. ALPERT, M.D.		22e. ADDRESS 8630 FENTON ST SILVER SPRING, MD. 20910		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 3/5/80	23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN	23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.	
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		25a. DATE REC'D. BY REGISTRAR MAR 4 1980		
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		25b. REGISTRAR'S SIGNATURE [Signature]		

500 (INCL. IN SILVER SPRING NO. 20901)
FRANCIS J. COLLINS
BIRTH 2/5/10

DATE OF DEATH

SILVER SPRING

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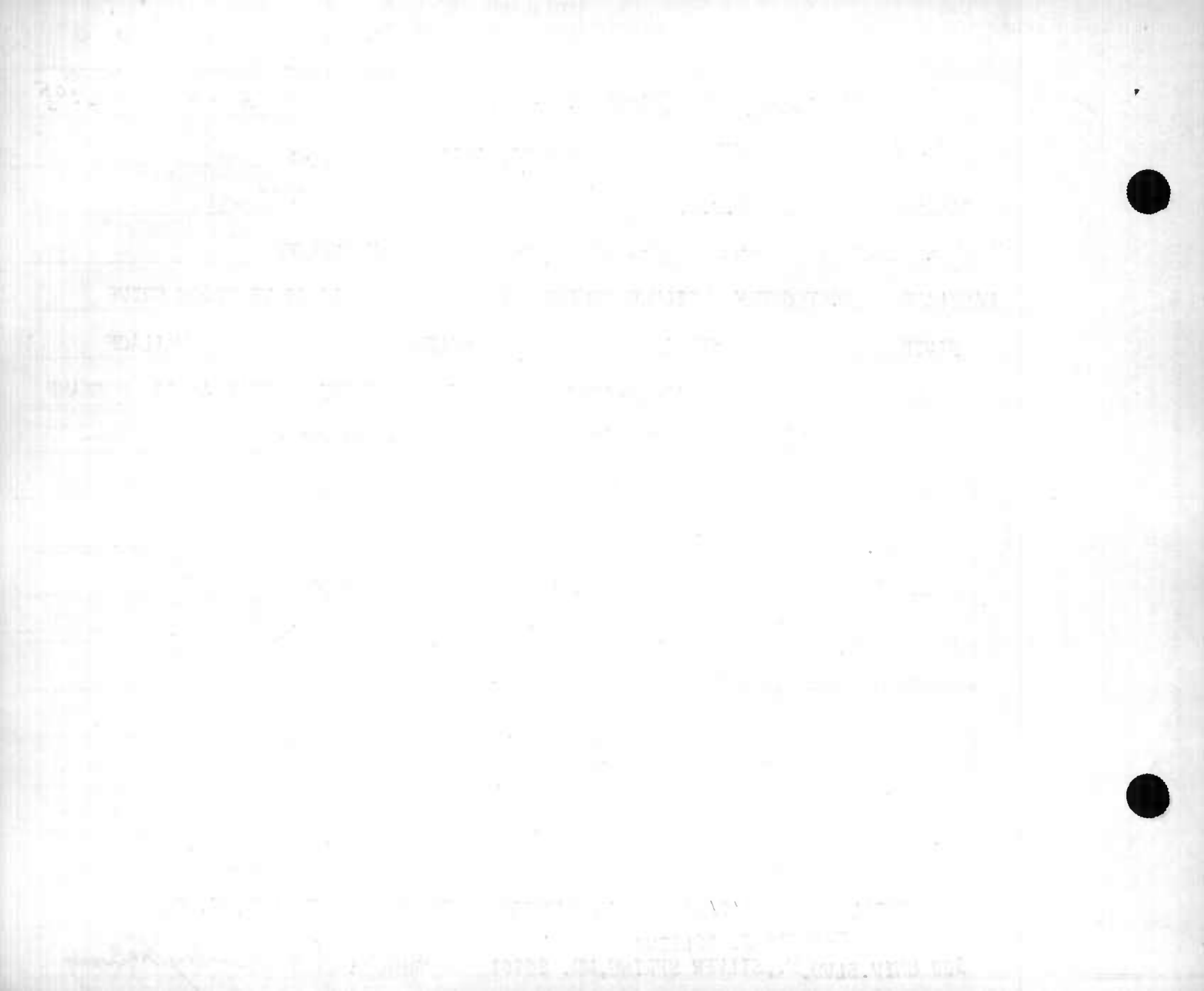
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0 0 7 7 6 8			
1. DECEASED NAME (TYPE OR PRINT) MARGARET Steel CURTIN				2a. DATE OF DEATH MONTH DAY YEAR 3 - 4 - 80			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 28, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CANADA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST DAVID STEEL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN WALLACE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 217-44-6753		17. INFORMANT JOHN JOSEPH CURTIN		ADDRESS SAME AS 13 HUSBAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST 4375 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARDIAC ARRHYTHMIA DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 MIN							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE X YEARS							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from BEFORE 1977 to MARCH 4, 1980 , that (I) (we) lost saw the deceased alive on MARCH 4, 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Arnold G. Levy M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-4-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARNOLD G. LEVY M.D.		22e. ADDRESS 1106 SPRING ST. SILVER SPRING, MARYLAND 20910					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/7/80		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		23d. LOCATION WASHINGTON, D.C. STATE	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR MAR 10 1980		25b. REGISTRAR'S SIGNATURE L. J. Kelly	
24. FUNERAL DIRECTOR ADDRESS 500 UNIV. BLVD. W., SILVER SPRING, MD. 20901							

BP



Items 18&22a G544 6/19/80 dad
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

07769

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH KNOWN ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR	
MARYANNE		CURTIS						3		24		19		80		3:20 AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
FEMALE	WHITE	JUNE 13, 1963		16 YRS.						3		24		19		80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH					
MOROCCO		U.S.A.										Montgomery County				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
GAITHERSBURG		Shady Grove Hospital		STUDENT													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MARYLAND		MONTGOMERY		SILVER SPRING		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9422 CURRAN ROAD									
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST							
PAUL		J.		CURTIS		EILEEN		A.		ROURKE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
NO		215-90-3190		PAUL J. CURTIS		SAME AS 13		FATHER									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 1 DEATH WAS CAUSED BY:																	
3049 IMMEDIATE CAUSE (a) Multiple drug intoxication																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
(b)																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 16 PART 1 OR PART 2)													
		P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Margarita A. Korell		Assistant		3-25-80													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Margarita A. Korell, M.D.		111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
BURIAL		3/27/80		GATE OF HEAVEN		SILVER SPRING MONT MD.											
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
FRANCIS J. COLLINS		MAR 26 1980		Francis J. Collins													
500 UNIV. BLVD., W., SILVER SPRING, MD., 20901																	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. AGREED DMV.
By FURER HUNTER

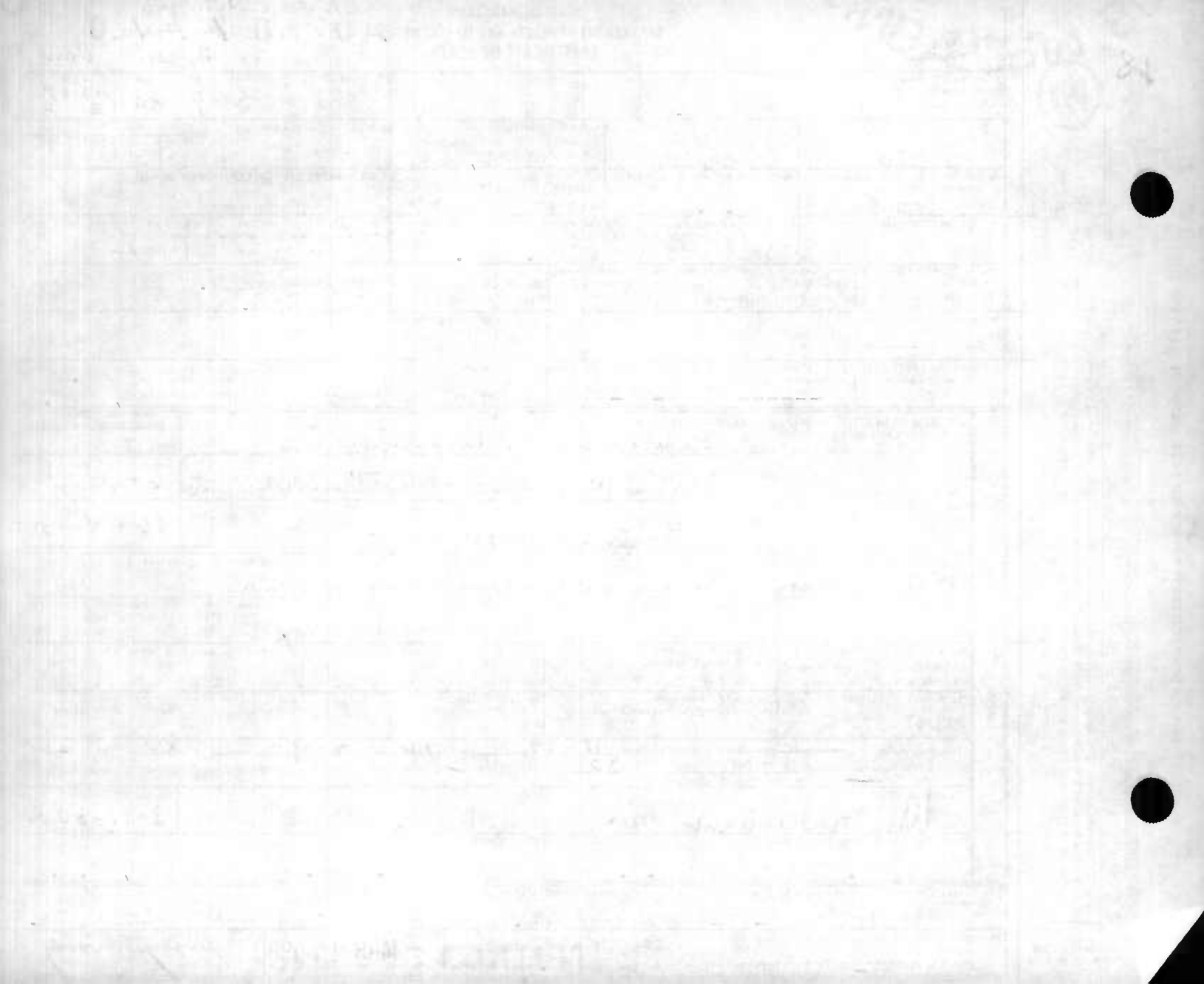
1. DECEASED NAME (TYPE OR PRINT) PAULINE S. CUTLER			2r. DATE OF DEATH MONTH DAY YEAR ~ 3 9 80			2b. HOUR 3 AM	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR April 11, 1907		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4716 Bradley Blvd. Apt. 212				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary	
13a. STATE Maryland		13c. CITY OR TOWN Chevy Chase		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13r. STREET ADDRESS Apt. 212 4716 Blvd. Chevy Chase	
14 FATHER'S NAME FIRST MIDDLE LAST Harry Stein				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Feldman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) ----- 029-01-9744		17 INFORMANT ADDRESS 13 Darby Ct. Mitchell Cutler Chevy Chase, Md.			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest - Ventricular Fibrillation</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH -	
4240 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Algebraic Heart Disease - Mitral Valve Replacement</u>		6+ years	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Mitral Insufficiency</u>		16+ years	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Kaposi's Sarcoma, Malignant Melanoma, Breast Cancer

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11-29</u> , 19 <u>80</u> , to <u>3-9-</u> , 19 <u>80</u> , that (I) was <u>did not</u> view the body after death.							
22b. SIGNATURE <u>Alan M. Weintraub M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-11-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alan M. Weintraub M.D.				22e. ADDRESS 5530 Wisc. Ave. Washington, D.C.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-13-1980		23c. NAME OF CEMETERY OR CREMATORY King Mem. Garden		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Fairfax Va.	
24 FUNERAL DIRECTOR NAME ADDRESS DANZANSKY-GOLDBERG CHAPELS MD.				25a. DATE RECD. BY REGISTRAR MAR 17 1980			



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

07171

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELSIE C. DA BBS			2a. DATE OF DEATH MONTH DAY YEAR 3-16-80			2b. HOUR 1145^{PM}	
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR March 13 1901		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Kensington			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3515 Anderson Road,	
14. FATHER'S NAME FIRST MIDDLE LAST Marmduke McCoy			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Troupe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none		17. INFORMANT ADDRESS William L. Dabbs-son-(same as 13e)		

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia, Hyperkalemia 5939 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Renal insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Urinary Tract Infection		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Rheumatoid Arthritis, Felty's Syndrome							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from 3-14 , 19 80 , to 3-16 , 19 80 , that (I) most last saw the deceased alive on 3-16 , 19 80 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above; (I) did not view the body after death.							
22b. SIGNATURE Robert T. Thibadeau				DEGREE		22c. DATE SIGNED 3/17/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT T. THIBADEAU				22e. ADDRESS Rockville, Md 20852			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 20, 1980		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Georges Md.	
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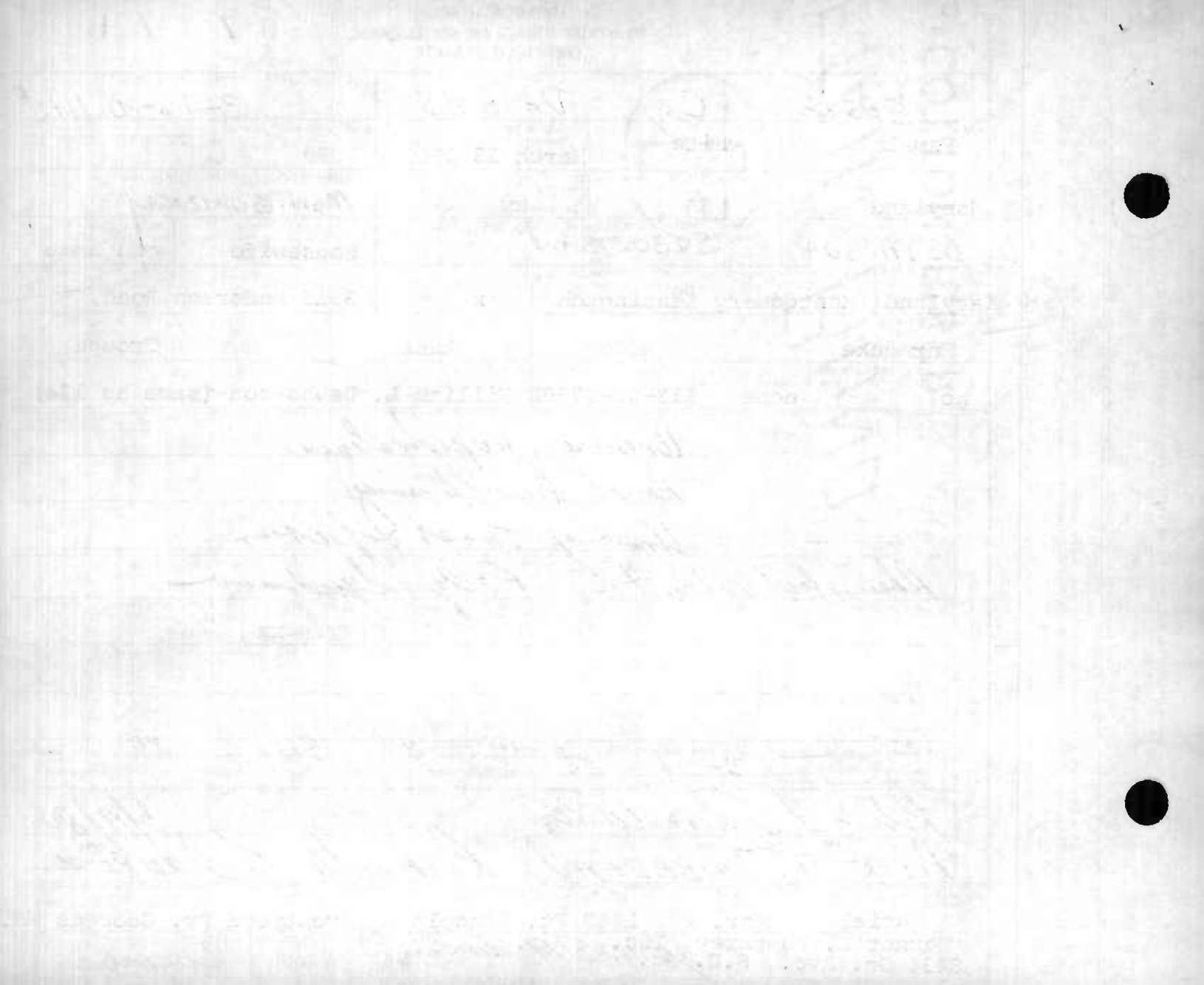
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.		25a. DATE REC'D. BY REGISTRAR MAR 20 1980		25b. REGISTRAR'S SIGNATURE Hilary McCready	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				07772			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Grace B Dague				2a. DATE OF DEATH MONTH DAY YEAR March 1 1980			
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 8 21 88		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KANSAS		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Asbury Village Health Care Ctr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William A Bradley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Hollenbeck		13e. STREET ADDRESS 4216 Lock Raven Blvd. Balt., Md.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 20-22-6833		17. INFORMANT ADDRESS Asbury Medical Records.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular arrhythmia 4 min DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure 6 mo DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease 5 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/14 19 74, to March 1 19 80, that (I) (we) last saw the deceased alive on Feb 12 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE James R. Moore Jr. MD				DEGREE MD		22c. DATE SIGNED 3-2-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James R. Moore Jr. MD				22e. ADDRESS 207 Brookes Ave Gaithersburg Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/6/80		23c. NAME OF CEMETERY OR CREMATORY Holton Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Holton Jackson Kansas	
24. FUNERAL DIRECTOR Gartner-Sandison F. H.		24b. ADDRESS 316 E. Diamond Ave Gaithersburg, Md.		25a. DATE REC'D BY REGISTRAR MAR 7 1980		25b. REGISTRAR'S SIGNATURE L. J. H. H. H.	

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UNITED STATES DEPARTMENT OF THE ARMY
HEADQUARTERS, ARMY
WASHINGTON, D. C.

TO: THE SECRETARY OF THE ARMY
FROM: THE CHIEF OF THE ARMY
SUBJECT: [Illegible]

[The following text is extremely faint and largely illegible due to fading and bleed-through from the reverse side of the page. It appears to be a memorandum or report.]



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[Illegible text]

100% COTTON FIBER

1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				07773			
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1 DECEASED NAME (TYPE OR PRINT)				2a DATE OF DEATH			
Pauline L. Davis				03/04/80 4:30 PM			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
Female		Caucasian		02/05/21		59 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Pennsylvania		U.S.A.				Montgomery Co MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hospital		Sect.		Railroad	
13a STATE		13b COUNTY		13c CITY OR TOWN		13d STREET ADDRESS	
Maryland		Montgomery		Rockville		1456 Bower Dr	
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
Michael		Anna		Yes			
16b SOCIAL SECURITY NO.		17 INFORMANT		18 ADDRESS			
182-14-8619		William E. Davis (Same as 13c)					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Pulmonary embolism							1 hr
DUE TO, OR AS A CONSEQUENCE OF (b)							3 yrs
Coronary artery disease							6 mo
DUE TO, OR AS A CONSEQUENCE OF (c)							
Paraplegia 2° to M.E.T.S.							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
Anemia							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR P.M. 19					
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) viewed attended the deceased from 19 28 to 3-4 19 80, that (I) viewed saw the deceased alive on 3-4 19 80, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did (did not) view the body after death.							
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED	
J. S. STIA		MD				3/4/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS					
J. S. STIA		809 Vickers Mill Rd Rockville Md.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION	
BURIAL		3-8-80		Parklawn Mem. Park		Rockville	
24 FUNERAL DIRECTOR Robert A. Pumphrey				25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Homes, P.A., Bethesda, Maryland				MAR 11 1980		L. H. McCrady	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										07174	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) ISABELLE B. DAWSON					2a. DATE OF DEATH MONTH 3 - DAY 16 - YEAR 80				2b. HOUR 6:00 A		
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH 10 DAY 27 YEAR 83		6. AGE (IN YEARS LAST BIRTHDAY) 96		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Veron, Indiana		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Rockville, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT NURSING FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret Public School Teacher		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9207 Adelaide Ct.				
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda							
14. FATHER'S NAME FIRST Thomas A. MIDDLE Batchelor LAST					15. MOTHER'S MAIDEN NAME FIRST Eleanor MIDDLE Basnet LAST						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Bethesda, Md. 20034 Margaret D. Hart-daughter 9207 Adelaide Ct.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) BILATERAL PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) INFLUENZA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MINUTES 1 DAY 6 DAYS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from AUG 1, 1979 to MARCH 16, 1980 , that (I) (we) last saw the deceased alive on MARCH 15, 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE Joseph D. Connor, MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED MARCH 16, 1980			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH D. CONNOR MD.					22e. ADDRESS BETHESDA, MD 20014 9420 OLD GEORGE TOWN RD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 3 / 16/80		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. 20002				
24. FUNERAL DIRECTOR NAME Lee Funeral Home ADDRESS 300-4th St. N.E. Wash.D.C. 20002					25a. DATE RECD. BY REGISTRAR 3-15-80		25b. RECEIVED BY REGISTRAR 3-15-80				

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

07775

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Lola L. Day			2a DATE OF DEATH MONTH DAY YEAR March 17, 1980			2b HOUR 7:45AM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Sept. 17, 1897		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Damascus		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 26945 Ridge Rd.	
14 FATHER'S NAME FIRST MIDDLE LAST William Edward Watkins					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie L. Hyatt				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-24-4702		17 INFORMANT ADDRESS Mrs Charlotte Whiddon, Item 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe coronary disease & cardiac dilatation</u> 2 yrs (c) <u>Atherosclerotic Heart Disease</u> 6 yrs.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Recurrent 2</u> <u>in 12 hrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Complete heart block; Chronic congestive heart failure; renal insuff; stroke brain injury</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) the hospital attended the deceased from <u>1974</u> 19 80 to <u>17 Mar</u> 19 <u>80</u> , that (I) was lost saw the deceased alive on <u>16 Mar</u> 19 <u>80</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) over (did) (did not) view the body after death.									
22b. SIGNATURE <u>Donald E. Dillon</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 17 Mar 80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald E. Dillon, M.D.				22e. ADDRESS 18111 Pr Philip Dr Olney, Md 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 20, 1980		23c. NAME OF CEMETERY OR CREMATORY Damascus Meth.		23d. LOCATION CITY OR TOWN COUNTY STATE Damascus, Montg., Md.			
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, Damascus, Md.				25. DATE REC'D. BY REGISTRAR MAR 19 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

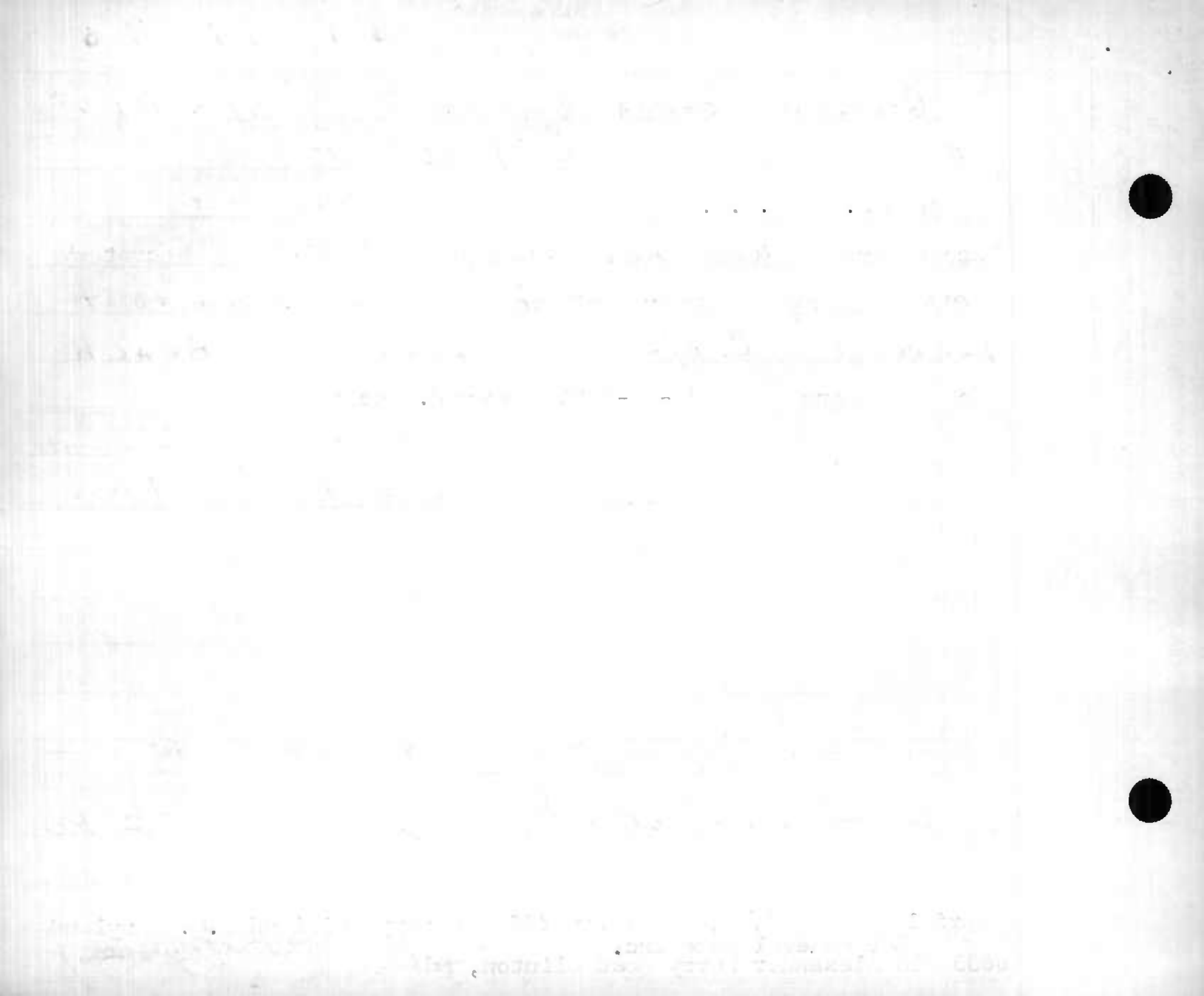
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 0 0 7 7 7 6				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GERALDINE BERTHA DEESE					2a. DATE OF DEATH MONTH DAY YEAR 3/26/80			2b. HOUR MIN 6⁵⁰	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 3 7 37		6. AGE (IN YEARS LAST BIRTHDAY) YRS 43		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Tacoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. Adv. Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled		12b. KIND OF BUSINESS OR INDUSTRY Secretary	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Ag. 13c. CITY OR TOWN Upper Marlboro 13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e. STREET ADDRESS 6504 Rosemond St.				
14. FATHER'S NAME FIRST MIDDLE LAST Lawrence Coppage					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lona Beach				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT Grover J. Deese		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central Nervous System Metastases DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of Breast DUE TO, OR AS A CONSEQUENCE OF (c) 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few weeks 4 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from MAY 1977 to 3/2 1980 , that (I) (we) last saw the deceased alive on 3/26 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE G. Leonard Gold					DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/26/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. LEONARD GOLD					22e. ADDRESS 8630 FENTON ST. SILVER SPRING MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/29/80		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.C. Maryland			
24. FUNERAL DIRECTOR NAME Lee Funeral Home Inc.					25a. DATE RECD. BY REGISTRAR APR 1 1980		25b. REGISTRAR'S SIGNATURE [Signature]		
6633 Old Alexander Ferry Road Clinton, Md.									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) ROBERT LEE DENNISON					2a. DATE OF DEATH MONTH MARCH DAY 14 YEAR 1980			2b. HOUR 1845PM	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH APRIL DAY 13 YEAR 1901		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. UNDER 1 YEAR MONTHS 0 DAYS 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAT'L NAVAL MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED Admiral		12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5040 WESTPATH TERRACE	
14. FATHER'S NAME FIRST LUDOVICI MIDDLE WATERS LAST DENNISON					15. MOTHER'S MAIDEN NAME FIRST FLORENCE MIDDLE LEE LAST LEE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 1919/1963		16c. SOCIAL SECURITY NO. 561-54-5077		17. INFORMANT Mildred Mooney Dennison ADDRESS MD. WIFE, 5040 WESTPATH TERRACE, BETHESDA			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY EMBOLUS 4151 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 1355/14MAR 1980 to 1845/14MAR 1980 , that (I) (we) last saw the deceased alive on 14 MAR 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>George T. Gamblin</i> DEGREE MD						22c. DATE SIGNED 15 MAR 1980			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE T. GAMBLIN						22e. ADDRESS NNMC XXXX BETHESDA, MARYLAND 20014			
23a. BURIAL, CREMATION, REMOVAL SPEC Cremation			23b. DATE 3/17/1980		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON, VIRGINIA		
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons Inc. ADDRESS 5130 Wisc. Ave., N.W.						25a. DATE REC'D. BY REGISTRAR MAR 19 1980		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

17

no more

17/10/20

Handwritten signature

17/10/20

Joseph White and Sons, Ltd. 17/10/20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 0 7 7 7 8			
1- STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) DANIEL L. DERR				2a. DATE OF DEATH MONTH DAY YEAR 3-22-80			
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR Sept. 25, 1907		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OR MOST OF WORKING LIFE) Elct. Eng/Teacher		12b. KIND OF BUSINESS OR INDUSTRY D.C. Government	
13a STATE Maryland		13b COUNTY A.A.		13c CITY OR TOWN Shadyside		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Charles Jacob Derr				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Knode			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO WW II		17 INFORMANT Marion H. Derr		ADDRESS Same as #13 Wife	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Probable acute myocardial infarction 15 min</u> (c) <u>atherosclerotic cardiovascular disease 20 yrs.</u> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>Cerebral anoxia post arrest</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/17</u> 19 <u>80</u> , to <u>3/22</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>3/22</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Samuel D. Goldberg MD				22c. DATE SIGNED 3-22-80		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Samuel D. Goldberg MD				22f. ADDRESS 11125 Rockville Pike, Rockville, Md.			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 3/26/80		23c. NAME OF CEMETERY OR CREMATORY George Washington Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Hyattsville P.G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland				25a. DATE REC'D BY REGISTRAR MAR 26 1980		25b. REGISTRAR'S SIGNATURE [Signature]	



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Handwritten text, mostly illegible due to bleed-through from the reverse side. Visible fragments include:
... 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 ...
... 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 ...
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(VRA 15, 4) 7/78

Items 13a to 13e g541 3/28/80 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 0 0 7 7 7 9

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Renee Dincin			2a. DATE OF DEATH MONTH DAY YEAR 3 14 80			2b. HOUR 44 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 10 00		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Roumania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home Maker	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Ch.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Meyerowitz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hannah (Unknown)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 071-22-9363		17. INFORMANT Dr. Irving Schneider Chevy Ch. Md.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 071-22-9363		17. INFORMANT Dr. Irving Schneider Chevy Ch. Md.		ADDRESS 5812 Warwick Pl.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ventricular fibrillation</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 min	
4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary heart disease</u> <u>ventricular irritability</u>		1 yr	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary heart disease</u>		—	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6-18</u> , 19 <u>79</u> , to <u>3-7</u> , 19 <u>80</u> , that (s) (we) last saw the deceased alive on <u>3-7</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Thomas H. Sinderson, MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-14-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS G. SINDERSON, MD.		22e. ADDRESS 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852					

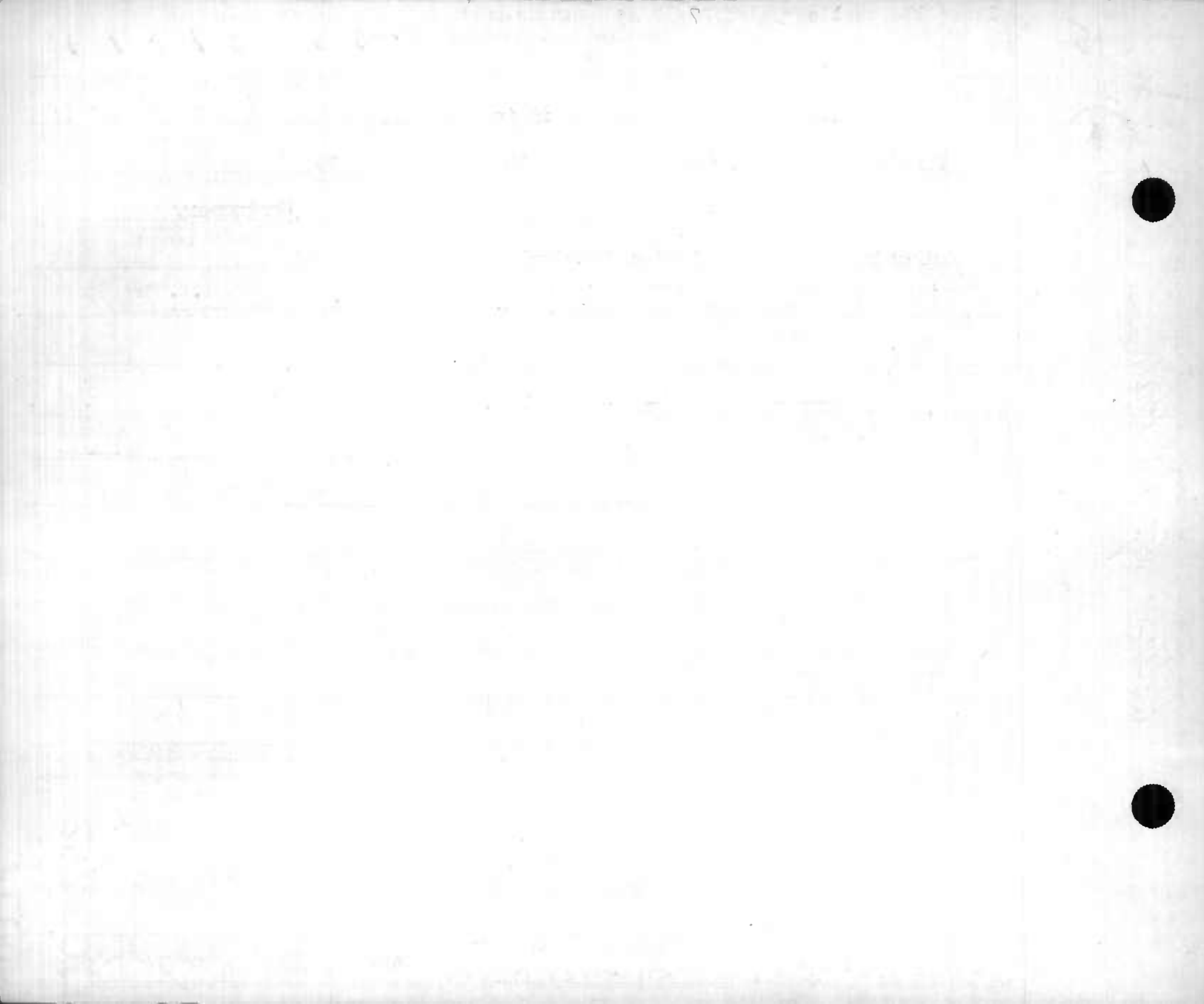
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-16-1980		23c. NAME OF CEMETERY OR CREMATORY Wellwood Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Farmingdale Suffolk N.Y.	
24. FUNERAL DIRECTOR NAME DANZANSKY GOLDBERG		ADDRESS 1120 ROCKVILLE PIKE ROCKVILLE, MD 20852		25a. DATE REC'D. BY REGISTRAR MAR 18 1980		25b. REGISTRAR'S SIGNATURE H. H. Brady	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Released by Dr. Ball



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be submitted within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 0 7 7 8 0

FOR
1 - STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) DONALD HOYT DOUD			2a DATE OF DEATH MONTH DAY YEAR MARCH 7, 1980			2b HOUR 8:50am							
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JANUARY 20, 1924		6 AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Scranton, Pa.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD							
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CLINICAL CENTER, NIH, BETHESDA, MD				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Marketing Specialist		12b KIND OF BUSINESS OR INDUSTRY					
13a STATE WILMINGTON				13b COUNTY New Castle		13c CITY OR TOWN DELAWARE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e STREET ADDRESS 3STONE'S THROW RD. 19803	
14. FATHER'S NAME FIRST MIDDLE LAST Laurence Field Doud				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marjorie Hoyt									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17 INFORMANT EDWINA DOUD (WIFE) (SAME AS PATIENT)		ADDRESS							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EXTENSIVE METASTATIC MALIGNANT MELANOMA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS			
1739 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										DUE TO, OR AS A CONSEQUENCE OF (b)			
										DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from FEBRUARY 18, 1980, to MARCH 7, 1980, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MARCH 7, 1980, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (we) did not view the body after death.													
22b SIGNATURE Joanne K Tobacman MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 3.7.80					
22d PHYSICIAN'S NAME (TYPE OR PRINT) Joanne Tobacman						22e ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MD 20205							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b DATE 3-8-80		23c NAME OF CEMETERY OR CREMATORY Lee's Crematory			23d LOCATION CITY OR TOWN COUNTY STATE Washington D.C. 20002					
24 FUNERAL DIRECTOR NAME Lee Funeral Home 300-4th St. N.E. Wash.D.C. 20002						25a DATE REC'D BY REGISTRAR MAR 20 1980		25b REGISTRAR'S SIGNATURE Mickey McCready					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										07781 REG. NO.	
1. FOR STATE REGISTRAR		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		Sharon		E.		Dove		ESTIMATED <input checked="" type="checkbox"/> 3.21		80 9:26 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR	
Female	White	May 18, 1953	26 YRS.	MONTHS DAYS HOURS MIN		March 21, 1980		9 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.	
D.C.		USA				Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda		Suburban Hospital		Executive Secretary		Secretarial					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5010 Augusta Lane			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
Charles V. Dove, Sr.				Ruth Fentiman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
No				579-78-0389				Charles V. Dove, Sr. Same As Item #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Multiple Injuries. Severe -</u>											
8147 } CONDITIONS, IF ANY, WHICH gave rise to immediate cause (a) stating the under- lying cause last.											
(b) <u>Trauma. Pedestrian Auto Accident.</u>											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				6:45 P.M. 3 21 1980		Struck by car when crossing St. Blown by gusty wind.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
				Street		Mass Ave. & Marilyn Dr. Ch. Ch. Montgomery Md					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
John S. Ball				Deputy				March 21, 1980			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
John G. Ball, M.D.				7936 Old Georgetown Rd. Beth., Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				Mar. 25, '80		Cedar Hill Cem.		Suitland, Md.			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash., D.C.				MAR 27 1980				[Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) STACY SHANNON DOWNING			2a. DATE OF DEATH MONTH DAY YEAR March 28, 1980			2b. HOUR 4:45pm			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 1, 1962		6. AGE (IN YEARS LAST BIRTHDAY) 17 YRS		7. UNDER 1 YEAR MONTHS DAYS 17	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL INSTITUTES OF HEALTH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY n/a	
13a. STATE VIRGINIA		13b. COUNTY Fairfax		13c. CITY OR TOWN SPRINGFIELD		13d. INSIDE CITY LIMITS? NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6702 REYNARD DRIVE 22152	
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS P. DOWNING				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty Cootes					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a		17. INFORMANT THOMAS P. DOWNING				ADDRESS SAME	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Failure 2770 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Cystic Fibrosis DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 29 Feb. 19 80 to 28 March 19 80 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 28 March 19 80 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did (did not) view the body after death.									
22b. SIGNATURE Alan C. Edge				DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/28/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN C. EDGE				22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MD. 20205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar 31, 1980		23c. NAME OF CEMETERY OR CREMATORY Fairfax Memorial Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Fairfax, Virginia		
24. FUNERAL DIRECTOR NAME Demaine Funeral Home, Alexandria, Va 22314				ADDRESS 22314		25a. DATE REC'D. BY REGISTRAR APR 3 1980		25b. REGISTRAR'S SIGNATURE [Signature]	

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RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

11/1/53

11/1/53

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W. C. Sullivan

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11/1/53

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 801 W. BALTIMORE
BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))
15M 7/76

1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				07783 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) June E Downs						2a. DATE KNOWN OF DEATH 3 14 1980		2b. HOUR 10:52 PM	
3. SEX female		4. RACE white		5. DATE OF BIRTH 10 15 23		6. AGE (IN YEARS) 56		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery		MD	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hos.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Telephone Op.		12b. KIND OF BUSINESS OR INDUSTRY C & P Tel.			
13a. STATE Md		13b. COUNTY Mont.		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 12618 Flack St.	
14. FATHER'S NAME William Smith		15. MOTHER'S MAIDEN NAME Lillian Wedding		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 77-26-1816		17. INFORMANT Edward O. Downs, Jr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4291 IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Chronic Myocardial Disease DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yes.		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None					
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) M.D. Rep.		MEDICAL EXAMINER 1919 Seminary Rd. Silver Spring, Md.		DATE SIGNED March 15, 1980			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 18, 1980		23c. NAME OF CEMETERY OR CREMATORY Sudley MethCh Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE		Clifton, Va.	
24. FUNERAL DIRECTOR NAME Homes, P.A.		ADDRESS Bethesda, Md.		25a. DATE REC'D. BY REGISTRAR MAR 21 1980		25b. REGISTRAR'S SIGNATURE [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with a 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) GOLDEN C. DRIVER, JR.					2a. DATE OF DEATH MONTH 3 DAY 21 YEAR 80			2b. HOUR 11:16 A.M.	
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH 1 DAY 15 YEAR 08		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Montg		13c. CITY OR TOWN TAKOMA PARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST Golden MIDDLE DRIVER LAST JR.		15. MOTHER'S MAIDEN NAME FIRST HATTIE MIDDLE LAST 							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-03-6934		17. INFORMANT ADDRESS MARGIE DRIVER (WIFE) SAME AS #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure 586- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Mar 20, 1980 to Mar 21, 1980 , that (I) (we) lost saw the deceased alive on Mar 20, 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Richard Schoenfeld				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/21/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Schoenfeld, M.D.				22e. ADDRESS 5530 Wisconsin Ave, Chevy Chase, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-25-80		23c. NAME OF CEMETERY OR CREMATORY ELIJAH CEMETERY		23d. LOCATION CITY OR TOWN FOOLESVILLE COUNTY MONTG STATE MD.			
24. FUNERAL DIRECTOR NAME GEORGE R. SNOWDEN ADDRESS 246 N. WASH ST. Rockville, Md.				25a. DATE REC'D. BY REGISTRAR MAR 28 1980		25b. REGISTRAR'S SIGNATURE Richard Schoenfeld			

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) Thomas Jensen DuMont Sr.				2a DATE OF DEATH MONTH DAY YEAR March 6 1980				2b HOUR 1015P M			
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Apr. 13 1912		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Capt.		12b KIND OF BUSINESS OR INDUSTRY U. S. Navy			
13a STATE Maryland				13b COUNTY Anne Arundel		13c CITY OR TOWN Annapolis		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 695 Americana Dr. Apt. 34	
14. FATHER'S NAME FIRST MIDDLE LAST Jerome DuMont				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mayme Jensen				16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes 1940-68			
16b SOCIAL SECURITY NO. 410 64 1834				17 INFORMANT Thomas J. DuMont Jr, 649 Kensington Ave./				ADDRESS Severna Park, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE PULMONARY EMBOLUS 1991 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) METASTATIC ADENOCARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I (this hospital) attended the deceased from Feb. 20, 1980, to Mar. 6, 1980, that I (we) last saw the deceased alive on Mar. 6, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) did (did not) view the body after death.											
22b SIGNATURE W.C. HAMILTON LT MC USNR				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 07MAR80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>W.C. Hamilton</i>				22e ADDRESS National Naval Medical Center, Bethesda, Md.							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b DATE 3-8-80		23c NAME OF CEMETERY OR CREMATORY Metropolitan Crem.		23d LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia			
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home Bethesda, Md.				ADDRESS				25a RECEIVED BY REG. PAR 25b REG. PAR 25c MAR 11 1980			



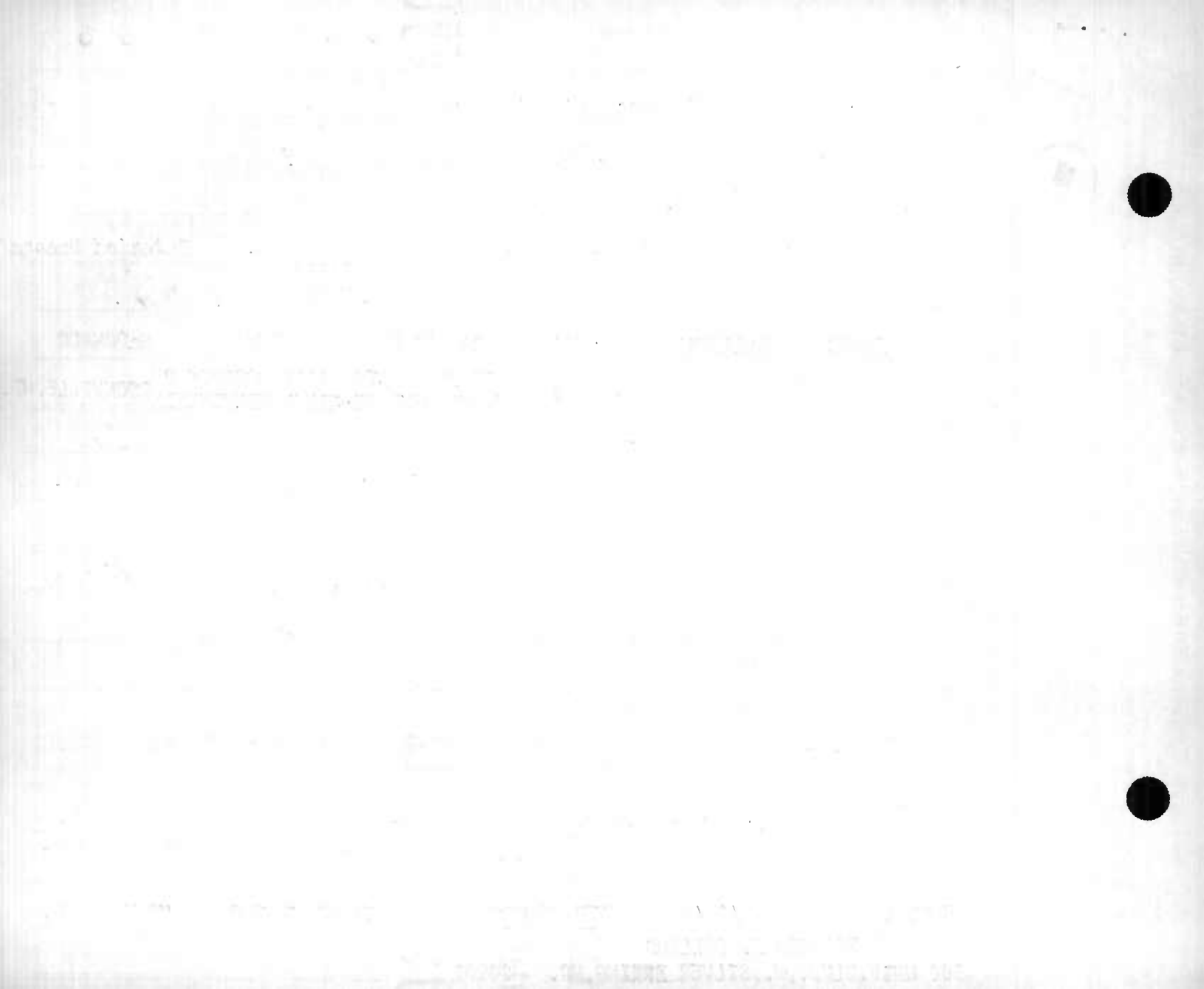
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon-jobs. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0 0 7 7 8 6			
1. DECEASED NAME (TYPE OR PRINT) <i>Lucille Florence DUNBAR</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>MARCH 11 1980</i>			
3. SEX <i>Female</i>				7b. HOUR <i>6:30 P.M.</i>			
4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>MAY 25 1905</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>74</i> YRS.		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>INDIANA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD.			
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Bel Pre Health Center</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Interior Decorator</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>MD</i> 13c. COUNTY <i>MONTGOMERY</i> 13d. CITY OR TOWN <i>Rockville</i>		14. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		15. STREET ADDRESS <i>14635 BAUER DR</i>			
16. FATHER'S NAME FIRST MIDDLE LAST <i>JAMES SULLIVAN PATTY</i>		17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>CAROLINE MELINDA McDONALD</i>		18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		19. SOCIAL SECURITY NO <i>086-16-42978</i>	
20. INFORMANT <i>LINDA DONATO</i> ADDRESS <i>4512 NORBECK RD ROCKVILLE, MD.</i>							
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> <i>4140</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic heart disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>See years.</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Generalized arteriosclerosis, senility, peripheral wet gangrene, diabetes mellitus, congestive heart failure</i>							
22a. DATE OF OPERATION		22b. CONDITION FOR WHICH OPERATION WAS PERFORMED		23a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		23b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
24a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		24b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
25a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK		25b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		25c. LOCATION STREET CITY OR TOWN COUNTY STATE			
26. I certify that (I) (the hospital) attended the deceased from <i>Jan 19 78</i> to <i>11 Mar 19 80</i> , that (I) (we) last saw the deceased alive on <i>21 Feb 19 80</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
27a. SIGNATURE <i>Donald E. Dillon M.D.</i> DEGREE <i>M.D.</i>				27b. DATE SIGNED <i>11 Mar 80</i>			
28a. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Donald E. Dillon, M.D.</i>				28b. ADDRESS <i>18111 Ar Philip & Olney, MD 20832 774-6655</i>			
29a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		29b. DATE <i>3/15/80</i>		29c. NAME OF CEMETERY OR CREMATORY <i>GATE OF HEAVEN</i>		29d. LOCATION CITY OR TOWN COUNTY STATE <i>SILVER SPRING MONT MD.</i>	
30. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i> ADDRESS <i>500 UNIV. BLVD., W. SILVER SPRING, MD. 20901</i>				31. DATE REC'D. BY REGISTRAR <i>MAR 17 1980</i>		32. REGISTRAR'S SIGNATURE <i>Anthony McCreedy</i>	





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 0 0 7 7 8 7						
1. DECEASED NAME (TYPE OR PRINT) Augusta B. DUNIEFF			2a. DATE OF DEATH March 26 1980			2b. HOUR 7:15A M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH June 28 1888		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS		7. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Government	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2817 Village Lane	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Berkowitz					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Messinger				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO 127 12 2179		17. INFORMANT ADDRESS Mrs. Ethel M. Raphael See item 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>4409</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probably Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from <u>October</u> , 19 <u>69</u> , to <u>March 26</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>March 26</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE <u>Aaron J. Friedman</u>					22b. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED Mar. 26, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Aaron J. Friedman, M.D.					22e. ADDRESS National Naval Medical Center Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-30-80		23c. NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Flushing New York		
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Memorial Chapel,					24b. ADDRESS Roackville, Md.		25. DATE REC'D. BY REGISTRAR		

Caroline Street

Nov 6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

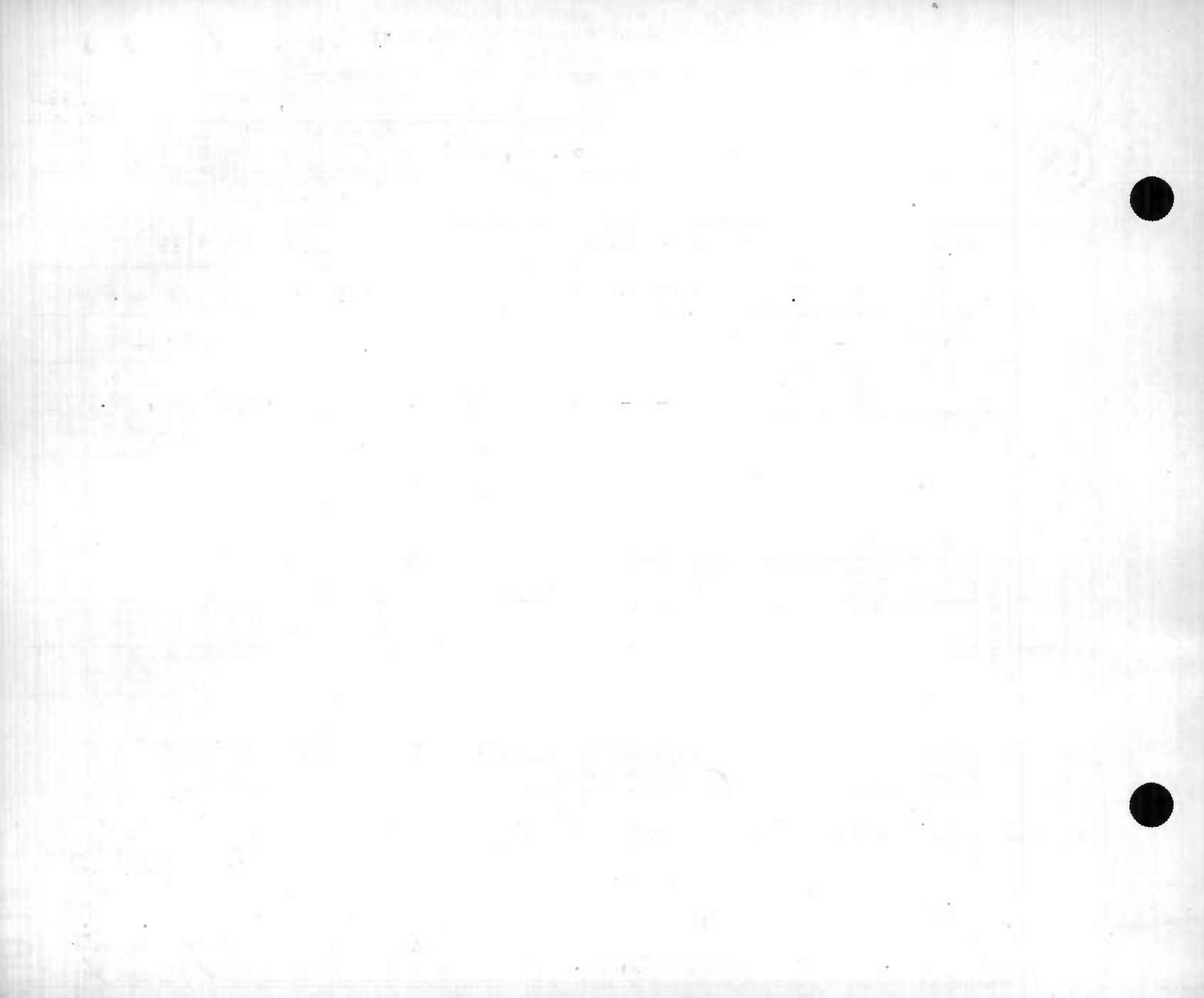
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

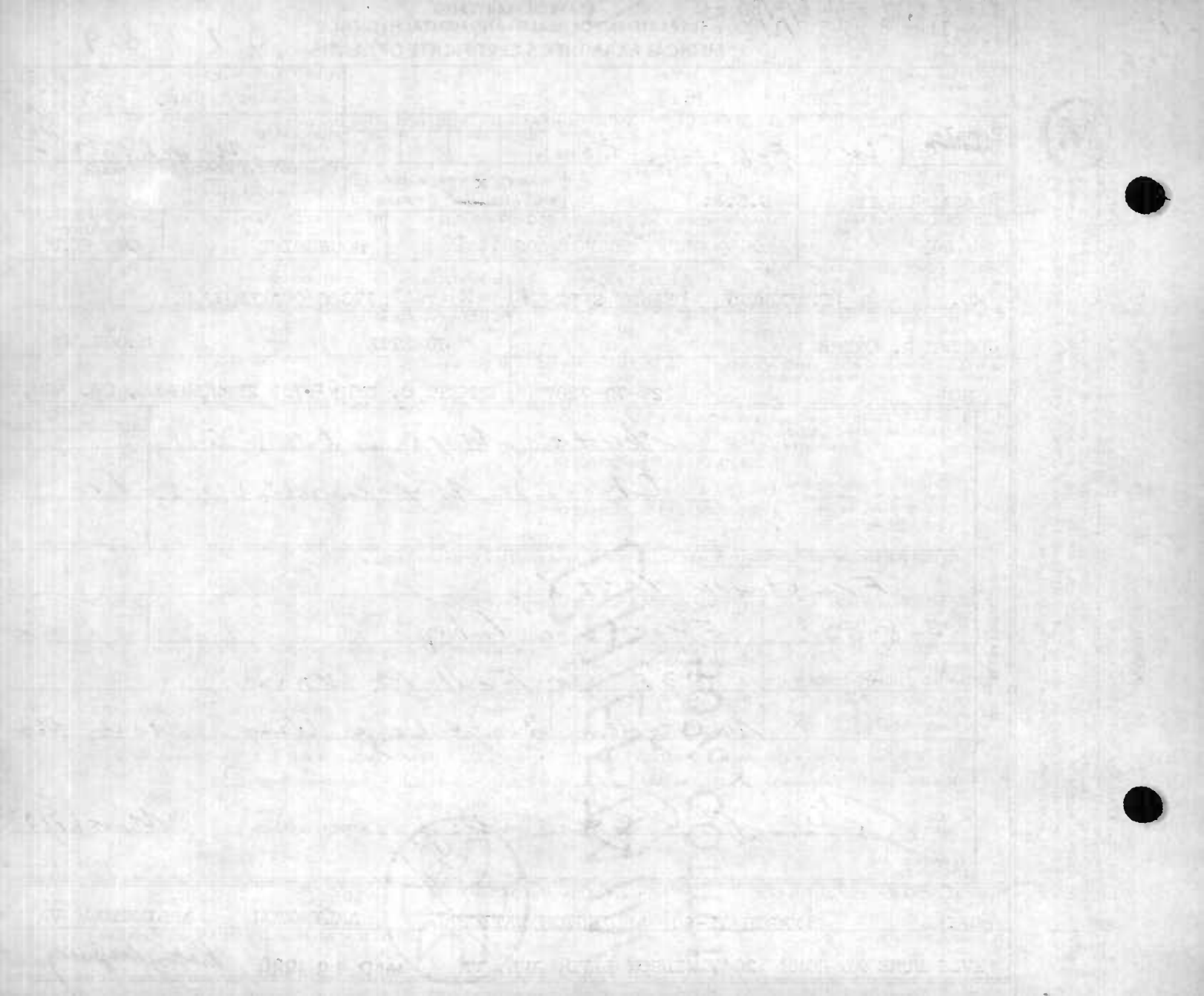
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR						7b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR						7b. HOUR	
ALFRED WARD DUVALL		March 6, 1980						12:55 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male	White	Nov. 26, 1906		73		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.	USA			Montgomery MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Gaithersburg	325 Muddy Branch Road			Printer			Printing		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS					
Maryland	Mont.	Gaithersburg	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	325 Muddy Branch Rd.					
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Scott - Duvall				Sarah L. Fairall					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
yes		WWII		Patricia D. Miles Gaithersburg, Md. 20760					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
436- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular Accident</u>								minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerosis</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Diabetes Mellitus; Hypertension</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <u>Jan. 24, 1980</u> to <u>3-6, 1980</u> , that (I) (we) lost saw the deceased alive on <u>Feb. 8, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
<u>Michael A. Bolognese</u>		M.D.				3-6-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
MICHAEL A. BOLOGNESE				19261 Montgomeray Village Ar Gaithersburg, Md. 20760					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		March 8, 1980		Forest Oak		Gaithersburg Mont. Md.			
24. FUNERAL DIRECTOR NAME				ADDRESS		25. DATE RECEIVED BY REGISTRAR		25b. SIGNATURE	
Francis H. Barber				Laytonville, Md. 20760		MAR 11 1980		<u>Michael A. Bolognese</u>	

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										07789 REG. NO.	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Katherine Grime Dye										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Mar. 8 1980	
3. SEX Female										2b. HOUR 11:07 AM	
4. RACE W										2c. DATE PRONOUNCED DEAD March 8 1980	
5. DATE OF BIRTH Feb 26 1944										2d. HOUR 11:07 AM	
6. AGE (IN YEARS) 38 YRS.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS										9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
7b. CITIZEN OF WHAT COUNTRY? U.S.A.											
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
10. CITY OR TOWN OF DEATH Olney										12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Montgomery General Hospital										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	
13a. STATE MD.										13b. COUNTY MONTGOMERY	
13c. CITY OR TOWN SANDY SPRING										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 17340 QUAKER LANE											
14. FATHER'S NAME JOSEPH R. GRIME										15. MOTHER'S MAIDEN NAME JUNETTA McDONALD	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO										16b. SOCIAL SECURITY NO. 223-70-7287	
17. INFORMANT EMMETT C. DYE										ADDRESS 13703 SPRUCEDALE, DR. ANN, VA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Chronic Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4291</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Fracture Left Hip</u>											
19a. DATE OF OPERATION 3-8-80										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture L. hip	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:35 1980	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fall in Room											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Nursing Home	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2000 Berkeley Dr. Olney Mont. Md											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE [Signature] M.D. [Signature] MEDICAL EXAMINER										TITLE (SPECIFY)	
EXAMINER'S NAME (TYPE OR PRINT)										DATE SIGNED March 8 1980	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL										23b. DATE MARCH 11-80	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL										23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON ARLINGTON VA	
24. FUNERAL DIRECTOR NAME IVE'S FUNERAL HOME										25a. DATE REC'D. BY REGISTRAR MAR 13 1980	
ADDRESS 2847 WILSON BLVD, ARL, VA										25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

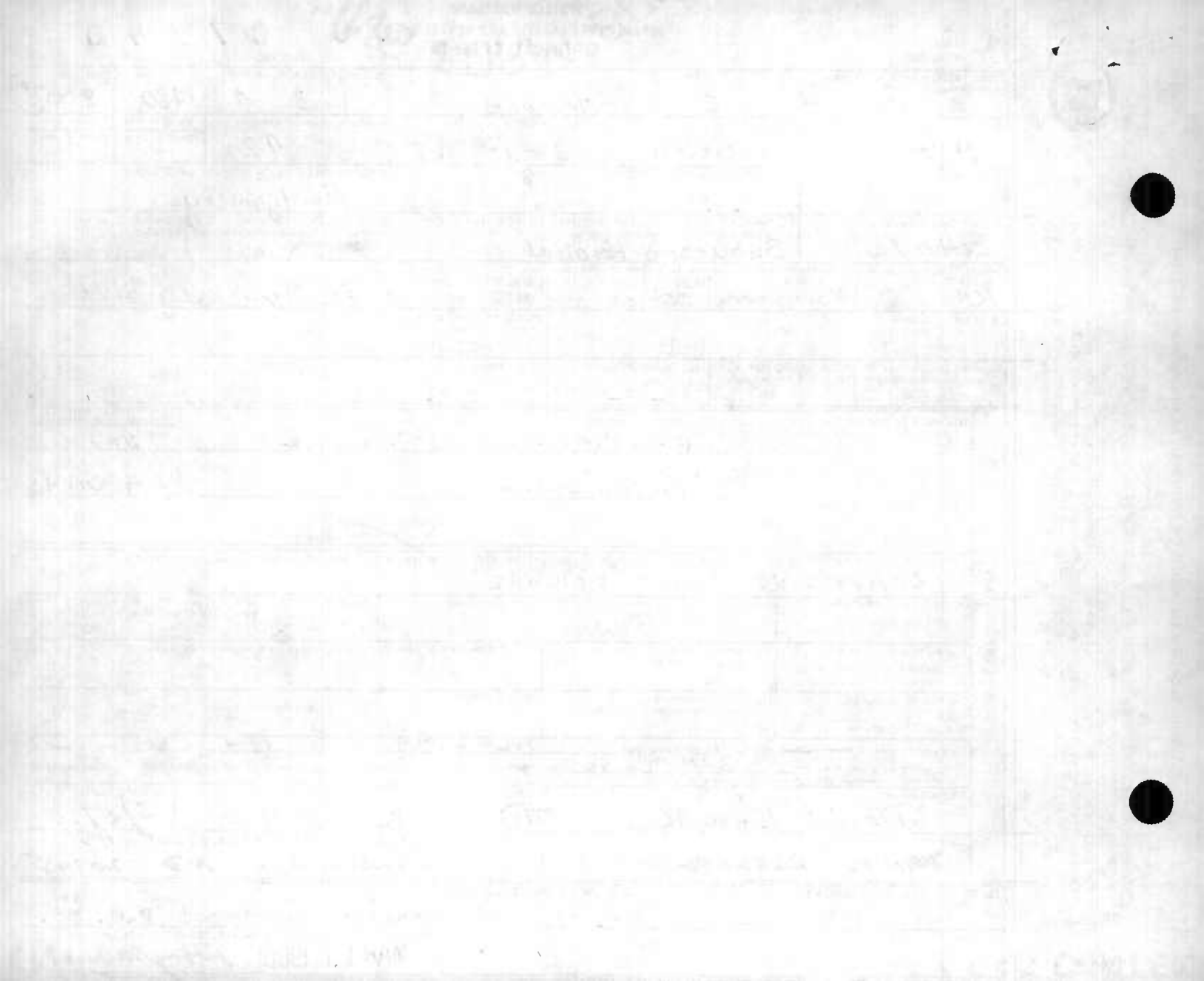
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Barnett I Edelsack			2a DATE OF DEATH MONTH DAY YEAR 3 4 1980			2b HOUR 8:45 PM					
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 3 17 87		6 AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physician		12b KIND OF BUSINESS OR INDUSTRY Medicine			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.			13b COUNTY Montgomery		13c CITY OR TOWN Bethesda		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 6530 Democracy Blvd.		
14 FATHER'S NAME FIRST MIDDLE LAST Mendel Edelsack			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Brina			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b SOCIAL SECURITY NO WW I 563-38-9426	
17 INFORMANT Edgar A. Edelsack			ADDRESS 3510 Hamlet Pl. Chevy Chase, Md.								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 486- HRS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) PNEUMONIA								DUE TO, OR AS A CONSEQUENCE OF 4 DAYS			
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CONGESTIVE HEART FAILURE											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a I certify that (I) (this hospital) attended the deceased from JULY 1979 to 3/4 1980 , that (I) (was) lost saw the deceased alive on 3/4 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Daniel Rosenblum						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 3/5/86	
22d PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL ROSENBLUM						22e ADDRESS 10400 CONNECTIONS AV KENSINGTON MD 20795					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b DATE 3-6-80		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory Brentwood P.G. Md.			23d LOCATION CITY OR TOWN		COUNTY	STATE
24 FUNERAL DIRECTOR NAME DANZANSKY GOLDBERG MEMORIAL CHAPELS						25a DATE REC'D. BY REGISTRAR MAR 11 1980		25b REGISTRAR'S SIGNATURE Hickey McCreedy			

BP



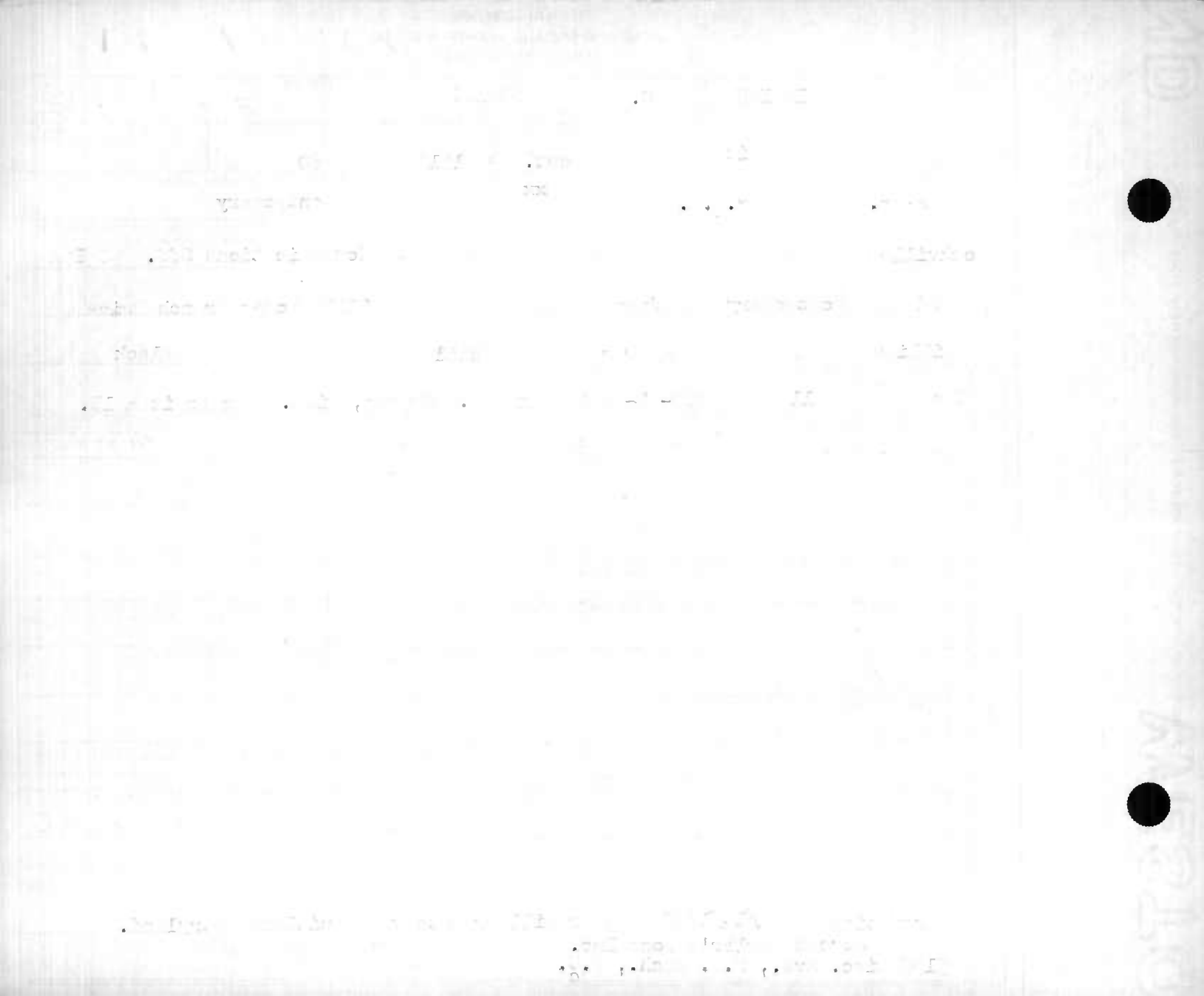
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

DHMH-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 07791	
1. DECEASED NAME (TYPE OR PRINT) FIRST WILLIAM MIDDLE O. LAST EDWARDS <i>William O. Edwards</i>			2a. DATE OF DEATH MONTH 3 DAY 8 YEAR 80			2b. HOUR 9:25 AM					
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH Sept. DAY 4 YEAR 1919		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 		8. IF UNDER 24 HRS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Communications		12b. KIND OF BUSINESS OR INDUSTRY Off. C I A			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md			13b. CITY OR TOWN Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7207 Thomas Branch Drive		
14. FATHER'S NAME FIRST William MIDDLE W LAST Edwards				15. MOTHER'S MAIDEN NAME FIRST Ethel MIDDLE LAST Black							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WW11 020-07-3608		17. INFORMANT ADDRESS Anne M. Edwards, Wife, Same as item 13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CVA 3314 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) HYDROCEPHALIC DEMENTIA (c) VENTRICULO-ATRIAL SHUNT INFECTION										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 6 years 6 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY 19 YEAR 		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 						
22a. I certify that (I) (this hospital) attended the deceased from May 19 79 to March 8 19 80 , that (I) (we) last saw the deceased alive on March 4 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE E. Morell				DEGREE 				22c. DATE SIGNED 3-8-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EVA M. MORELL				22e. ADDRESS 7936 OLD GEORGETOWN RD BETH. MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 3/10/1980		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory			23d. LOCATION CITY OR TOWN Suitland COUNTY Maryland STATE 			
24. FUNERAL DIRECTOR Joseph Lawler's Sons Inc. NAME 5130 Wisc. Ave., N.W. Wash., D.C. ADDRESS 						25a. DATE OF REGISTRATION MAR 14 1980		25b. REGISTRAR'S SIGNATURE 			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) SUE. First May Middle Eilbacher Last			2a. DATE OF DEATH 3 Month 19 Day 80 Year		2b. HOUR 10:25 AM
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 5/8/1897	
6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Montgomery Md.		10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerk-typist		12b. KIND OF BUSINESS OR INDUSTRY GSA		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	
13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 6818 Connecticut Ave.		14. FATHER'S NAME First John Middle Walter Last Estes		15. MOTHER'S MAIDEN NAME First Addie Middle M. Last Hardenbergh	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 577-44-1760		17. INFORMANT Address Adrienne E. Hollis, same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4029 Intracerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) 30 yrs APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	
21f. LOCATION Street or R.F.D. No. City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from 1975 to March 19, 1980 , that (I) (we) last saw the deceased alive on March 19, 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE G. Stuart Scott DEGREE G. Stuart Scott, M.D.		22c. DATE SIGNED 3/19/80 MD.		22d. PHYSICIAN'S NAME (Type) G. Stuart Scott, M.D.	
22e. ADDRESS 10401 Old Georgetown Rd., Bethesda		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE 3/21/80		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D.C.	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A.		25a. RECEIVED BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE John M. Chesley	

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

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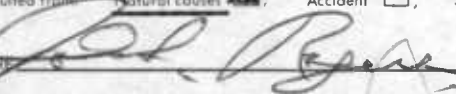

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND										07/93					
DEPARTMENT OF HEALTH AND MENTAL HYGIENE															
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
FOR REGISTRAR										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST Marie			MIDDLE Ellen			LAST Ellis			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 3/16 19 80		2b. HOUR 10:00 P. M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 7, 1899		6. AGE (IN YEARS) LAST BIRTHDAY 80 YRS.		IF UNDER 1 YR. MONTHS DAYS 00 00		IF UNDER 24 HRS. HOURS MIN. 00 00		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3/17 19 80		2d. HOUR 7:15 A. M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.						
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 311 Dale Drive			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY Hecht Co.						
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 311 Dale Drive				
14. FATHER'S NAME FIRST MIDDLE LAST Alfred D. Ellin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Johnson			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no none			16b. SOCIAL SECURITY NO. 578-10-1421			17. INFORMANT (son) 6932 University Dr. Roy T. Ellis, Jr. Alex., Va. 22307			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial disease. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a) stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None															
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE 			TITLE (SPECIFY) Deputy			DATE SIGNED 3/17/80			1919 Seminary Road Silver Spring, Montgomery, Md.						
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.			ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE March			23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Washington, DC						
24. FUNERAL DIRECTOR NAME Warner E. Pumphrey, Inc.			ADDRESS 8434 Ga. Ave., S.S. Md.			25a. DATE REC'D. BY REGISTRAR MAR 20 1980			25b. REGISTRAR'S SIGNATURE 						

John S. Roberts, M.D.

Silver Spring, Montgomery, Md.

Deputy

3/17/80

XX

XX

None

None

None

Acute myocardial disease.

Maryland Montgomery Silver Spring 311 Dale Drive

Silver Spring 311 Dale Drive

Montgomery County XX

Female White Nov. 7, 1899 80

Maryland Hills

XX 3/16 80

3/17 80 7/12

10:00

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										07794 REG. NO.	
1- STATE REGISTRAR		FIRST		MIDDLE		LAST		7a. DATE KNOWN OF DEATH		7b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		EARLE		W.		EISENMAN		3 17 19 80		11:50	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR
male	white	12 19 1932		47	MONTHS DAYS		HOURS MIN.		3 17 19 80		11:50
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Washington, D.C.		U.S.A.		WIDOWED		DIVORCED		Montgomery County			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR					
Chevy Chase		8900 Connecticut Avenue		Asst. Rt. Manager		paper					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Montgomery		Chevy Chase		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8900 Connecticut Avenue			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Francis Joseph Eisenman		Eva Belle Baker		No		217-30-0811		Eva B. Eisenman		Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?					
PART 1 DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
IMMEDIATE CAUSE (a)											
4292											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b)											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION							
				STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/>		Inspection <input type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion			
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED							
Margarita A. Korell		Assistant		3-18-80							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
Margarita A. Korell, M.D.		111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		3-20-80		Parklawn Mem. Park		Rockville		Montgomery		Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
NAME		MAR 24 1980		MARGARITA KORELL							
HOMES, P.A., Bethesda, Maryland											

(continued)

Page 111, "Total", "Others"

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

07795

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ALICE FAY Ellis			2a. DATE OF DEATH MONTH DAY YEAR March 1 1980			2b. HOUR 6:10 P.M.			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 1 2 1991			6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colonial Villa Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auditor		12b. KIND OF BUSINESS OR INDUSTRY Int. Rev.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY OR TOWN Maryland Montgomery Silver Spring									
13b. STATE Maryland			13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Charles J Johnston			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Alice Leazer						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 579 53 8222			17. INFORMANT ADDRESS Vera B Scobey Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary Arrest								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Stroke, Hypertension, Diabetes									
DUE TO, OR AS A CONSEQUENCE OF (c) Stroke, Hypertension, Diabetes									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from May 10th , 19 76 , to Aug 23rd , 19 79 , that (I) (we) lost saw the deceased alive on Feb 7th , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Rajindra K. Sarin DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 3.3.80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAJINDRA K. SARIN						22e. ADDRESS 6201 Greenbelt Rd College Park MD 20740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar 5 1980		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland		
24. FUNERAL DIRECTOR NAME Robert E Wilhelm ADDRESS Suitland Maryland						25a. DATE REC'D. BY REGISTRAR MAR 7 1980		25b. REGISTRAR'S SIGNATURE Patricia A. Bayley	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

[illegible]

Page 20

vedon? 8. arvi? 2.3

10/10/2007

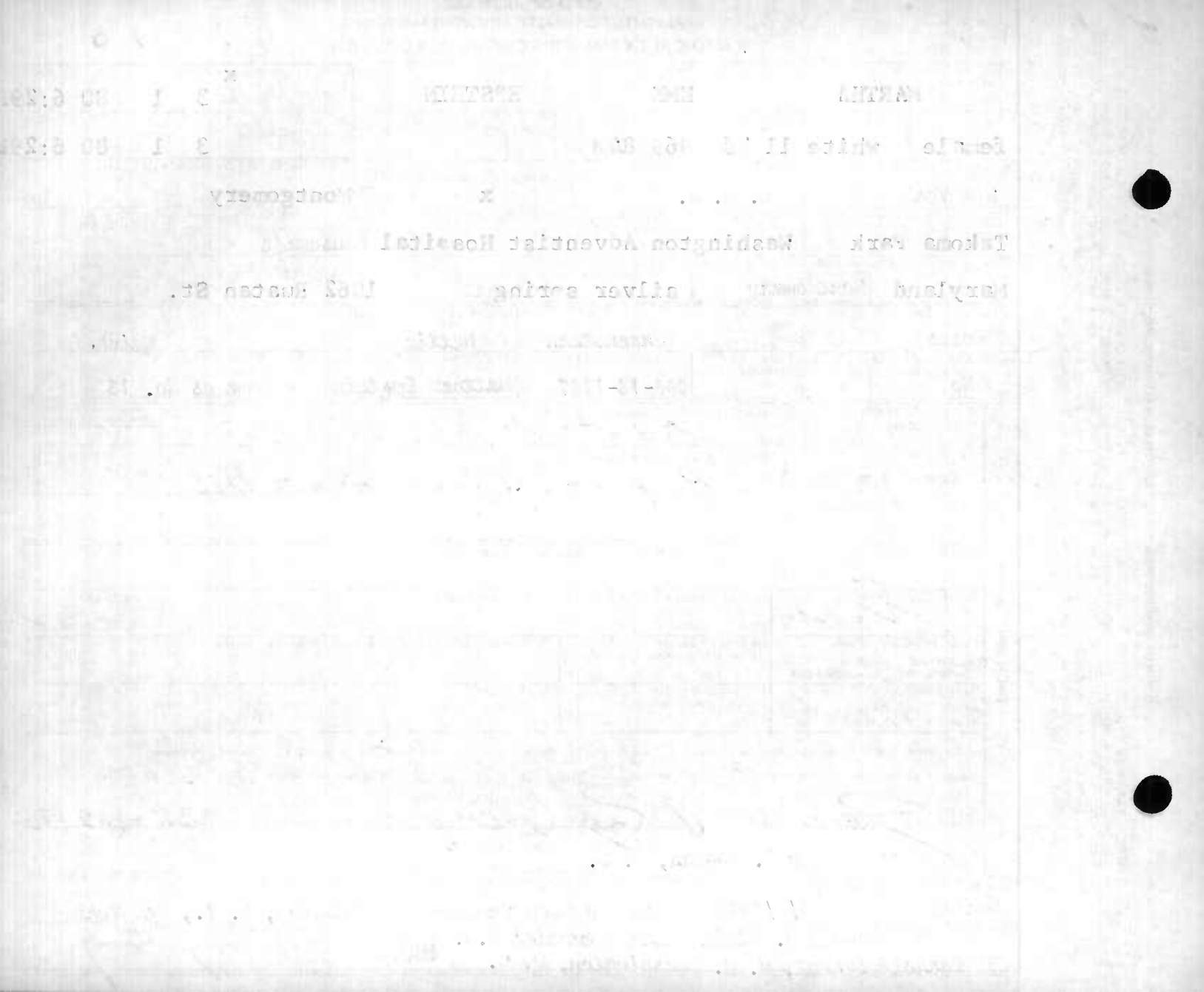
Received 11 July 1980

161208

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 07796	
1- STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARTHA NMN EPSTEIN						2a. DATE KNOWN OF DEATH. MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3 1 19 80		2b. HOUR 6:29 PM					
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 11 25 1895		6. AGE (IN YEARS) 1. BIRTHDAY 2. YRS. 84		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 1 19 80		2d. HOUR 6:29 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Takoma Park				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN silver spring		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1062 Ruatan St.			
14. FATHER'S NAME FIRST MIDDLE LAST Moses Morgenstern						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie Weinreib							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 066-18-1167		17. INFORMANT Matthew Epstein				ADDRESS Same as No. 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. 4029 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Hypertensive Heart Dis. DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None													
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE John S. Rogers				TITLE (SPECIFY) M.D. Dep.				MEDICAL EXAMINER				DATE March 2, 1980	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M. D.				ADDRESS									
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial				23b. DATE 3/4/1980		23c. NAME OF CEMETERY OR CREMATORY Mount Hebron Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Flushing, L. I., New York			
24. FUNERAL DIRECTOR NAME Donald M. Stein				HEBREW MEMORIAL F.H. 232 Carroll Street, N. W. Washington, D. C.				25a. DATE REC'D. BY REGISTRAR MAR 6 1980		25b. REGISTRAR'S SIGNATURE Jeffrey McCurdy			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 0 7 7 9 7							
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR					
I. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST					March 25, 1980			1:00 P				
Margaret F. Ernst																	
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. UNDER 1 YEAR		7. UNDER 24 HRS				
Female			Caucasian		July 9, 1890			89 YRS			MONTHS DAYS		HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH		
New York					U.S.A.										Montgomery County MD.		
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Rockville					Collingswood Nursing Home					Homemaker			Home				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. CITY OR TOWN					13b. STREET ADDRESS							
13a. STATE					13b. CITY OR TOWN					13c. INSIDE CITY LIMITS?			13d. STREET ADDRESS				
Virginia					Arlington					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1900 Columbia Pike				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME												
FIRST MIDDLE LAST					FIRST MIDDLE LAST												
Lawrence Frawley					Not Available												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT					ADDRESS		
No					057-20-8062					Amanda R. Ernst, Same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>										3 minutes							
5908 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septicemia</u>										3 days							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>pyelonephritis</u>										3 weeks							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic Brain Syndrome</u>																	
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
					P.M. 19												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from <u>Sept 1975</u> to <u>March 25, 1980</u> , that (I) (we) last saw the deceased alive on <u>March 25, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>John F. Tauber M.D.</u> DEGREE <u>M.D.</u>										22c. DATE SIGNED <u>3-25-80</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS							
John F. Tauber, M.D.										8212 Wisconsin Ave. Bethesda, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial					3/29/80		St. Raymond's Cem.			Bronx County, New York							
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Robert A. Pumphaey Funeral Homes, P.A. Rockville, Maryland										MAR 28 1980			<u>Richard McCreedy</u>				

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The death certificate is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 07798	
1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Anna Errigo				2a. DATE OF DEATH MONTH DAY YEAR March 30, 1980				2b. HOUR 12:09am	
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 25, 1890		6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) ITALY		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN OLNEY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4601 MORNINGWOOD DRIVE	
14 FATHER'S NAME FIRST MIDDLE LAST DIEGO SCOPELLITI				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARMELA UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-62-6994		17. INFORMANT DEAN P. ERRIGO		ADDRESS SAME AS 13		SON			
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c. PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute myocardial infarction 410 - DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from 3/25/80 to 3/30/80, that (1) (we) last saw the deceased alive on 3/30/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death)											
22b. SIGNATURE MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/30/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN G. LODWELL, MD.				22e. ADDRESS 18111 Prince Philip Dr., Olney, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/1/80		23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S		23d. LOCATION WASHINGTON, D.C.		STATE			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR APR 3 1980		25b. REGISTRAR'S SIGNATURE [Signature]					
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											

2000 LONDON 1900

CHIEF OF POLICE



500 LINDEN AVE. N. SILVER SPRING, MD. 20901	FRANCIS J. COLLINS	4/1/10	ST. MARYS	WASHINGTON, D. C.
NO	578-62-6994	CLEAN T. ENIGG	DATE AS IS	20X
7237	SCOTLAND	CALIFORNIA	INDICATE	
HAWAIIAN	HONOLULU	OLIVE	XX	1801 HONOLULU DRIVE
ELVIS	U.S.A.	1		HONOLULU
ITALY				ON 10/10/10
FEMALE	WHITE	JULY 27, 1900	89	
				10:00

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM-17
(VR A15 ME (5))
15M 7/77

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

07799

1. DECEASED NAME (TYPE OR PRINT) Jerome H. Etelson			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 3 7 1980			2b. HOUR 1:50 PM			
3. SEX M	4. RACE CAUC	5. DATE OF BIRTH MONTH DAY YEAR 2 28 32	6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 7 1980			2d. HOUR 1:50 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BROKER		12b. KIND OF BUSINESS OR INDUSTRY FINANCIAL	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10017 ORMOND RD	
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS G. ETELSON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY A. BUDOFF					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 577-40-5994		17. INFORMANT ADDRESS BERNARD CRAVATH (ATTY) KENSINGTON, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410 - CORONARY Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) CORONARY ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE 24 hrs. INDEF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR PM P.M. 3 6 1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) CHEST PAIN AT HOME				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 10017 ORMOND RD BETHESDA MONT MD				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE Francis C. Mayhew Jr. MD				TITLE (SPECIFY) Deputy			MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayhew Jr. MD				DATE SIGNED 3/7/80					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3/9/80		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEM. GARD.			23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH, FRFX, VA.	
24. FUNERAL DIRECTOR DANIEL ZANSKY-GOLDBERG MEM. CHAPEL, ROCKVILLE, MD.					25a. DATE REC'D. BY REGISTRAR MAR 13 1980		25b. REGISTRAR'S SIGNATURE Helen M. Brady		

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

ST. JAMES

1914

Internal Revenue

Receipt

100

100



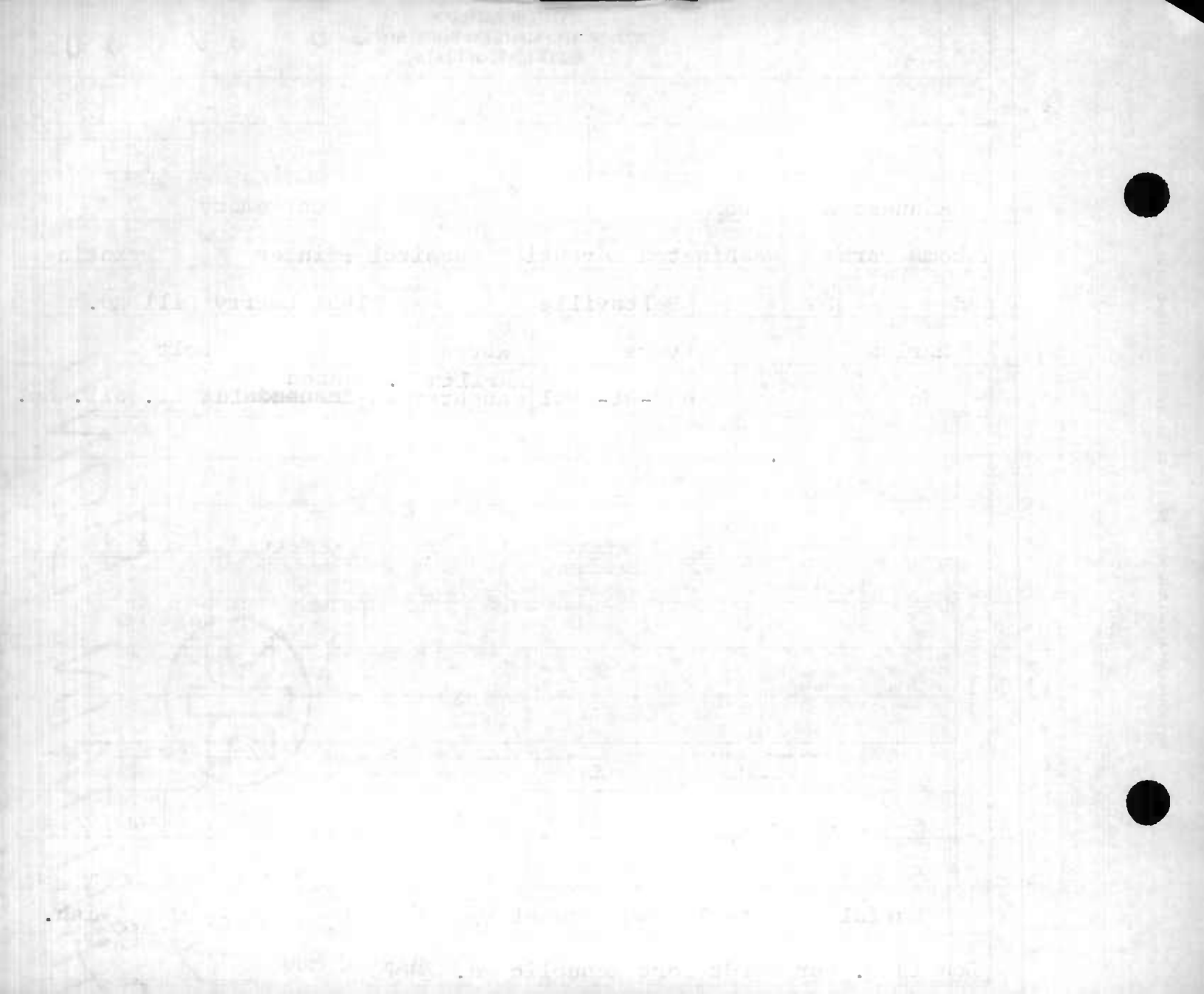
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7. REG. NO.		0 0 7 8 0 0					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Howard Barney Evers						2a. DATE OF DEATH MONTH DAY YEAR 3-14-80		2b. HOUR 3:07 AM	
3. SEX Male		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 4 25 00		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 79		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer		12b. KIND OF BUSINESS OR INDUSTRY Printing	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY PG 13c. CITY OR TOWN Beltville 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						13e. STREET ADDRESS 1431 Cherry Hill Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Evers				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Karen Holt					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 468-01-4901		17. INFORMANT ADDRESS Marilyn E. Benson daughter 10 Shanandale Ct. Sil. Sp.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 410 - Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY ATHEROSCLEROSIS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 days 2-3 days Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) HYPERTENSION - DIABETES MELLITUS									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (i) (this hospital) attended the deceased from MAY 1976 to MAR 14 1980 , that (i) (was) last saw the deceased alive on MAR 13 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert B. Irey				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED MAR 14, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT B. IREY				22e. ADDRESS 11161 New Hampshire Ave Silver Spring Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 3-17-1980		23c. NAME OF CEMETERY OR CREMATORY Sunset MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE MINNEAPOLIS HENNEPIN Minn.			
24. FUNERAL DIRECTOR NAME Donald V. Borgwardt Port Republic Md.				25a. DATE REC'D. BY REGISTRAR MAR 20 1980					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

07801

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Mildred Barber Fairfax								Mar. 12 80					12 44 PM
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
FEMALE	WHITE		MARCH 17, 1891		88 YRS.				MONTGOMERY		MD.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
MARYLAND	U.S.A.		Brooke Grove Foundation		BOOKKEEPER								
10. CITY OR TOWN OF DEATH	13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
OLNEY	MARYLAND		MONTGOMERY		SANDY SPRINGS		YES <input type="checkbox"/> NO <input type="checkbox"/>		NONE				
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
LEMUEL A.	DORA N. SCAGGS		NO		578-62-5051		GRANDSON STEVE BARBER		6432 OVERBROOK ST FALLS CHURCH, VA.		22043		
18. CAUSE OF DEATH (Enter only one cause per item for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular failure</u> <u>1539</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Longstanding heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia Ca. of Colon</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
3/10/79		Intestinal resection & hysterectomy		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) (this hospital) attended the deceased from 19 75, to 3/12/80, that (1) (we) lost saw the deceased alive on 3/12/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
C. H. L. [Signature]		1811 Pr Philip Dr											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
BURIAL		3/15/80		Cedar Hill Cemetery		SUITLAND		PRI GEO		MD.			
24. FUNERAL DIRECTOR		25a. DATED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
FRANCIS J. COLLINS		MAR 1 1980		[Signature]									
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901													

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1- FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT) EDWARD JOSEPH FARRELL						LAST FARRELL		2b. DATE KNOWN OF DEATH March 15, 1980		2c. MONTH DAY YEAR 15 80	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH March 31, 1936		6. AGE (IN YEARS) 43		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2d. DATE PRONOUNCED DEAD March 15, 1980	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENN.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3303 Tidewater Ct						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPT.		12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION			
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Olney		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3303 Tidewater Ct					
14. FATHER'S NAME JOSEPH - MIDDLE FARRELL LAST						15. MOTHER'S MAIDEN NAME MARGARET * MIDDLE MARTIN LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 1954		17. INFORMANT Mary Ann Farrell				ADDRESS Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 1629 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Carcinoma of lung DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None													
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE John S. Rogers				TITLE (SPECIFY) MD				MEDICAL EXAMINER				DATE SIGNED March 15, 1980	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, MD				ADDRESS Silver Spring, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE MARCH 18, 1980		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven				23d. LOCATION CITY OR TOWN Silver Spring, Mont. Md.			
24. FUNERAL DIRECTOR FRANCIS H. BARBER				LAFONSVILLE, MD. 20760				25a. DATE REC'D BY REGISTRAR MAR 19 1980		25b. REGISTRAR'S SIGNATURE [Signature]			

THE UNIVERSITY OF CHICAGO
LIBRARY



FOR STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO. 0007803

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FARRAR

2a DATE OF DEATH MONTH DAY YEAR 3 23 80

2b HOUR 2:30 AM

3 SEX female

4 RACE cauc.

5 DATE OF BIRTH MONTH DAY YEAR MARCH 23, 1924

6 AGE (IN YEARS (LAST BIRTHDAY)) 56 YRS.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York

7b CITIZEN OF WHAT COUNTRY? U.S.A.

8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.

10 CITY OR TOWN OF DEATH BETHESDA

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife

12b KIND OF BUSINESS OR INDUSTRY

13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE Md. 13c COUNTY Mont. 13d CITY OR TOWN Wheaton 13e INSIDE CITY LIMITS? YES ☐ NO ☐ 13f STREET ADDRESS 4404 Mahan Rd.

14 FATHER'S NAME FIRST MIDDLE LAST Emmett J. Hodge

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Norton

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes 16b SOCIAL SECURITY NO. WW II 17 INFORMANT ADDRESS Ruben Thompson Farrar same as 13

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intra cerebral Hemorrhage 431- DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ① Hyper tension ② Breast Cancer - treated Surgically

19a DATE OF OPERATION 19b CONDITION FOR WHICH OPERATION WAS PERFORMED 19c AUTOPSY? YES ☐ NO ☒ 19d IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☒

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f LOCATION STREET CITY OR TOWN COUNTY STATE

22 I certify that (I) (this hospital) attended the deceased from 3/22, 1980, to 3/23, 1980, that (I) (we) lost saw the deceased alive on 3/23, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) saw the body after death.

22a SIGNATURE Jeffrey Drobis DEGREE MD 22b DATE SIGNED 3/24/80

22c ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22d PHYSICIAN'S NAME (TYPE OR PRINT) Jeffrey Drobis 22e ADDRESS 10500 Summit Ave Kensington Md

23a BURIAL, CREMATION, REMOVAL (SPECIFY) cremation 23b DATE 3/25/80 23c NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria Virginia 23d LOCATION CITY OR TOWN COUNTY STATE

24 FUNERAL DIRECTOR NAME Francis J. Collins ADDRESS 500 Univ. Blvd. W. Silver Spring Md. 20901 25a DATE REC'D. BY REGISTRAR MAR 26 1980 25b REGISTRAR'S SIGNATURE Jeffrey Drobis

FACTORY

EXTRACTION

APRIL 23, 1924

U.S.A.

NEW YORK

58

Housenick

1101 10th St.

Liberty

10th St.

NY

George

10th St.

NY

Frank

Norton

Ruben Thompson 10th St. NY

NY

NY

Virginia

Alexander

Washington

2/25/20

Extraction

Frank J. Collins

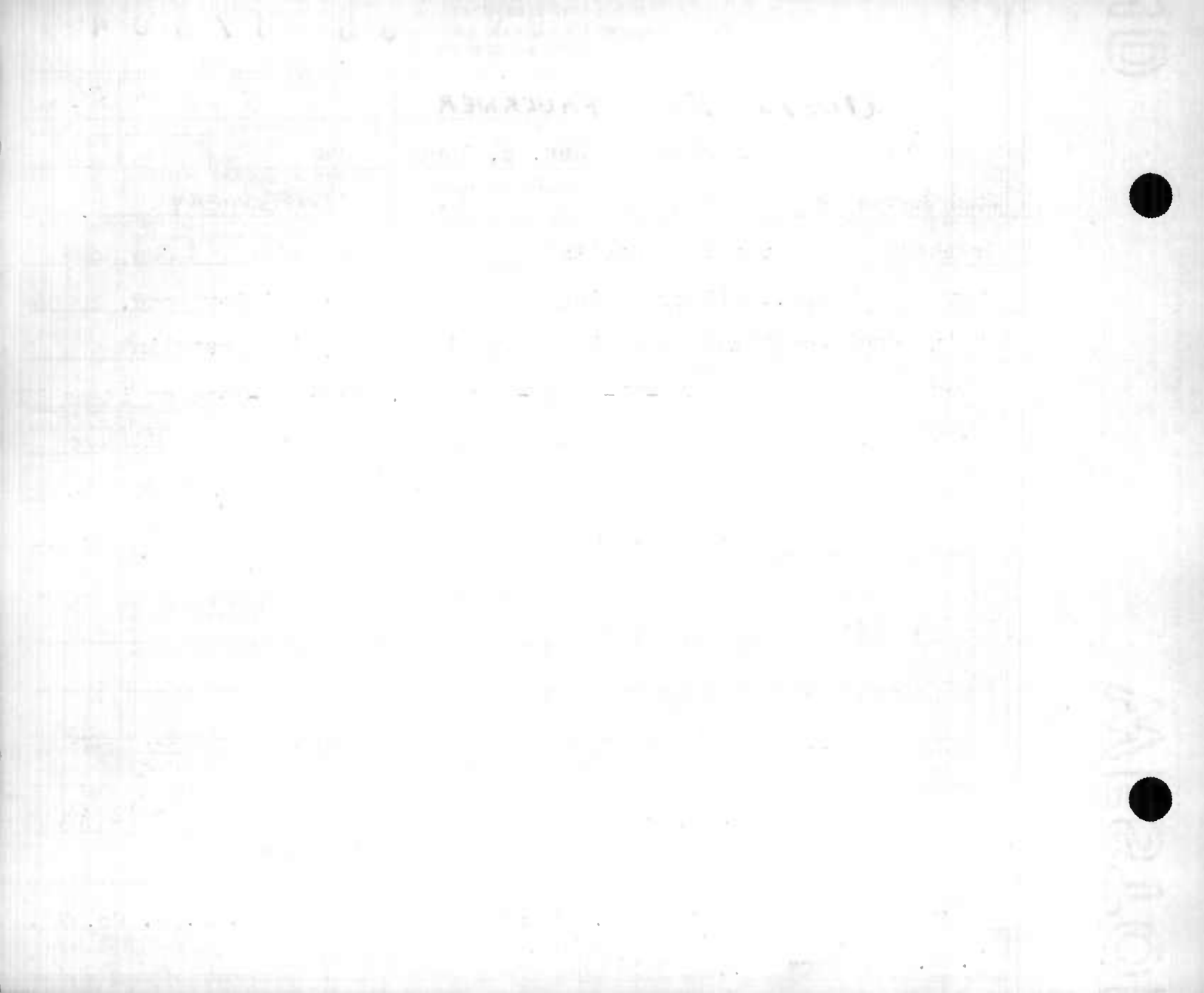
MAR 2 1920

10th St. NY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0 0 7 8 0 4			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) JULIA F. FAULKNER				MONTH 3 DAY 22 YEAR 80		2b. HOUR 5⁴⁰ AM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH Jan. DAY 6 YEAR 1906		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. STREET ADDRESS	
13a. STATE Maryland		13b. COUNTY Mont.		13c. CITY OR TOWN Silver Spring		13d. STREET ADDRESS 4400 Gridley Road. 20906	
14. FATHER'S NAME FIRST Julius MIDDLE Carl LAST Ferdinand Stommel				15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Ellen LAST Josephine Franklin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 579-01-9024		17. INFORMANT ADDRESS A-Vernon L. Faulkner-Same as items 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DISSEMINATED INTRAVASCULAR COAGULOPATHY							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 4472 DUE TO, OR AS A CONSEQUENCE OF (b) MASSIVE UPPER-GI BLEEDING							48 hrs
DUE TO, OR AS A CONSEQUENCE OF (c) AORTODUODENAL FISTULA							48 hrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION 3/20/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED AORTODUODENAL FISTULA		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) the hospital attended the deceased from 3/20 , 19 80 , to 3/22 , 19 80 , that (I) (we) lost saw the deceased alive on 3/21 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Louis Kornoff, MD DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/22/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis Kornoff, MD				22e. ADDRESS 8218 WISCONSIN AVE BETHESDA, MD 20014			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/25/80		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P. G. Co. Md.	
24. FUNERAL DIRECTOR NAME W. W. Chambers Co., Silver Spring, Maryland				25a. DATE REC'D. BY REGISTRAR MAR 26 1980		25b. REGISTRAR'S SIGNATURE Anthony McCready	





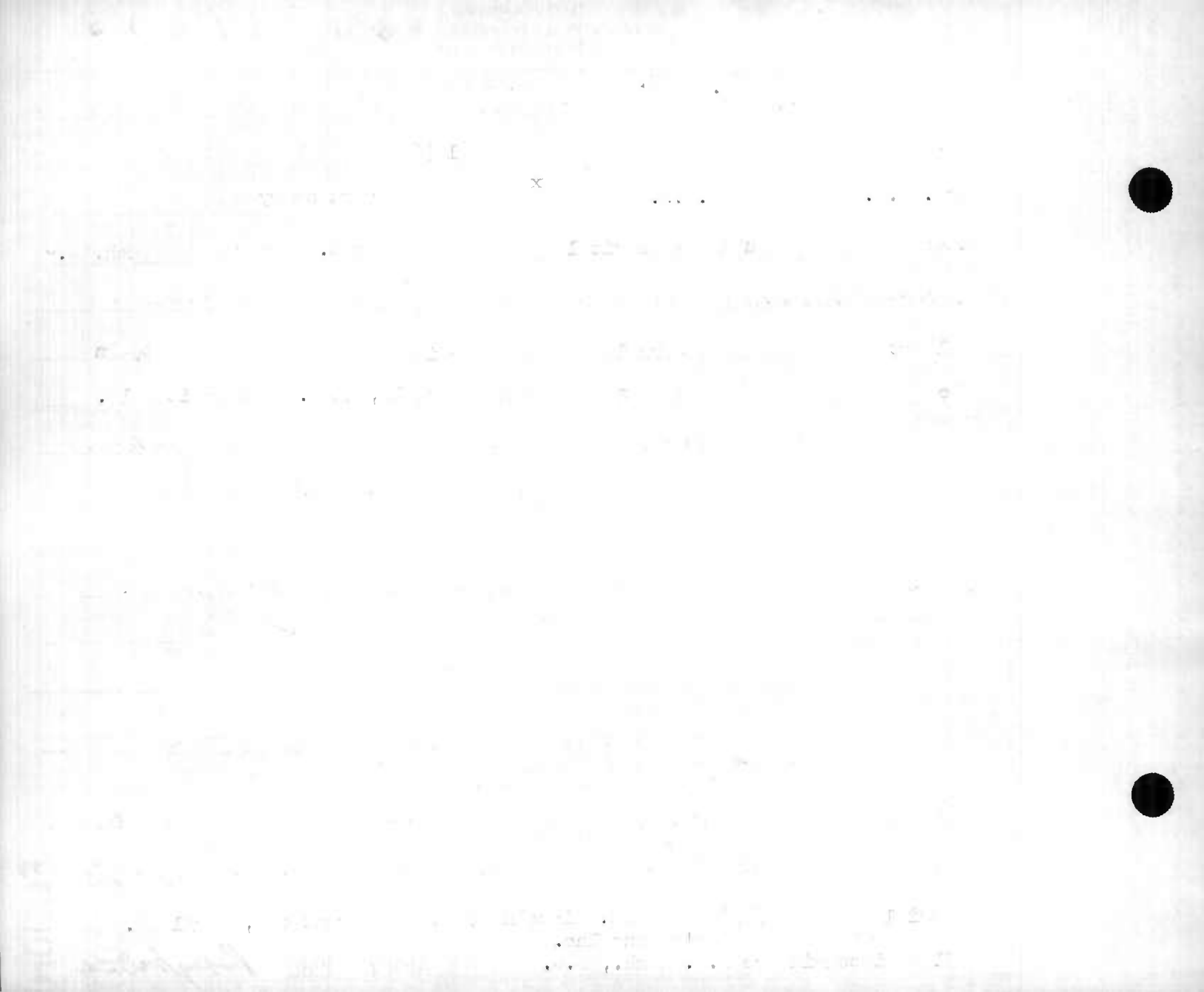
Page 2 of 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG NO 0 0 7 8 0 5							
1. DECEASED NAME (TYPE OR PRINT)		FIRST KENNETH MIDDLE G. LAST FERNALD		2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
KENNETH G FERNALD				MARCH 31-1980			10 P M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
MALE		WHITE		10-30-1896		83 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Wash. D.C.		U.S.A.				Montgomery MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hospital				Asst. Surveyor		Wash. D.C.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MARYLAND		MONTGOMERY		CHEVY CHASE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7304 MAPLE AVENUE	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
Albert Fernald		Bessie St John							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No		Unknown		Leah E Fernald, Wife. S me as item 13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) CARDIAC ARREST									
4140 DUE TO, OR AS A CONSEQUENCE OF									
(b) ARTERIO SCLEROTIC HEART DISEASE YEARS									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
DIABETES MELLITUS CHRONIC RENAL FAILURE ANEMIA									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from July 1962, to 31 March 1980, that (I) (we) last saw the deceased alive on 31 March 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE		DEGREE				22c. DATE SIGNED			
William Howard Yeager Jr MD						31 March 80			
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS							
William Howard Yeager Jr		1808 Conn Ave NW, Wash D.C. 20009							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		4/3/1980		Ft. Lincoln Cemetery		Brentwood, Maryland			
24. FUNERAL DIRECTOR NAME				24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Joseph Gawler's Sons Inc.				5130 Wisconsin Ave N.W. Wash., D.C.		APR 7 1980		P. H. H. H.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 07806			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph Gibson Terrier				2b. HOURS MIN 3:00 PM			
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 18, 1910		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN 70 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Book Binder		12b KIND OF BUSINESS OR INDUSTRY U.S. Govt	
13a STATE 13b COUNTY 13c CITY OR TOWN Maryland Montgomery Takoma Park				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 228 Park Ave	
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Terrier				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unk			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unk		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Unk		17 INFORMANT Richard Terrier, Prince Frederick, Md		ADDRESS 219 Cassell Blvd	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 respiratory failure (b) underlying disease (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 5/19 to 5/19, that (I) (we) lost the deceased alive on 5/19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b SIGNATURE Lew H. Dennis				22c DATE SIGNED 5/25/80		22d PHYSICIAN'S NAME (TYPE OR PRINT) Lew H. Dennis	
22e ADDRESS 831 University Blvd S.S. Md				22f ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE MAR 23 1980		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md	
24 FUNERAL DIRECTOR NAME W.W. Chambers, 8655 Georgia Ave S.E. Sps				25a DATE REC'D BY REGISTRAR MAR 26 1980		25b REGISTRAR'S SIGNATURE Anthony McBrady	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Finkelstein, David					2a. DATE OF DEATH MARCH 3, 1980			2b. HOUR 0115 AM	
3. SEX M		4. RACE CAUC.		5. DATE OF BIRTH 02-12-1895		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 0 20 - -	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mailman		12b. KIND OF BUSINESS OR INDUSTRY Postal Service	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		
14. FATHER'S NAME FIRST MIDDLE LAST Morris Jacob Finkelstein					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Golda Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes					16b. SOCIAL SECURITY NO. WWI 092-30-8623		17. INFORMANT Ethel Finkelstein, 6111 Montrose, Rockville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 years 8 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Influenza									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 22, 1978, to March 3, 1980, that (I) (we) last saw the deceased alive on Mar 3, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Stephen Fred					DEGREE MD			22c. DATE SIGNED 3-3-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN FRED					22e. ADDRESS 5001 SILVER HILL RD SUITLAND, MD. 21083				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-4-80		23c. NAME OF CEMETERY OR CREMATORY New Montefiore, N. Y.		23d. LOCATION CITY OR TOWN COUNTY STATE Long Island, N. Y.		
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEM. CHAP. Rockville, Md.					25a. DATE REC'D. BY REGISTRAR MAR 7 1980		25b. REGISTRAR'S SIGNATURE [Signature]		

100-100000
RECEIVED IN THE
OFFICE OF THE
DIRECTOR

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MAR 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Maudie E. FOGERTY			2a. DATE OF DEATH MONTH DAY YEAR March 27 1980				2b. HOUR 6:30A M		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept, 4 1908		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Librarian		12b. KIND OF BUSINESS OR INDUSTRY Govt,	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D. C.			13b. COUNTY 13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3621 Martin Luther King Ave, S.E.		
14. FATHER'S NAME FIRST MIDDLE LAST George Storey			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Harman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 579 66 0440		17. INFORMANT ADDRESS Edwin F. Fogerty 327 Empress Dr, Houston, Tx 77034				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> 1820 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ENDOMETRIAL CARCINOMA</u> (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 27</u> , 19 <u>80</u> , to <u>Mar. 27</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Mar. 27</u> , 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>W.D. Harris MD</u>			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>3/28/80</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. D. Harris, M. D.			22e. ADDRESS National Naval Medical Center, Bethesda, Md,						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/29/80		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. George Md.		
24. FUNERAL DIRECTOR NAME Kalas Funeral Home, Oxon Hill, Md,			ADDRESS Hill, Md,		25a. DATE REC'D. BY REGISTRAR APR 1 1980		25b. REGISTRAR'S SIGNATURE <u>Anthony McCready</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>FLORA FORTNER.</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>MARCH-25-1980</i>		2b. HOUR <i>4:15 P.M.</i>	
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12 28 1893</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>86</i> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VA.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH <i>Mont.</i>			MD.			
10. CITY OR TOWN OF DEATH <i>TAKOMA PARK</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>3190 Gardens Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>Md.</i>		13b. COUNTY <i>Montg.</i>		13c. CITY OR TOWN <i>Dickerson</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Ruffus Pennington</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>UNKNOWN</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>226-92-0985</i>		17. INFORMANT ADDRESS <i>Mrs. Musser - Dickerson Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac arrest.</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>E. Myocardial infarction</i>						
DUE TO, OR AS A CONSEQUENCE OF (c) <i>CHF</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>8-17-79</i> , 19 <i>80</i> , to <i>3-25</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>3-17</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>SMITH H O M D</i>				22e. ADDRESS <i>8323 HADDON DR TAKOMA DR PK MD</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>3/28/80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Frederick Frederick Md.</i>
24. FUNERAL DIRECTOR NAME ADDRESS <i>W.C. Helt</i> <i>Burien Rd.</i>				25a. DATE REC'D. BY REGISTRAR <i>APR 3 1980</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6000

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		3. SEX		4. RACE		5. DATE OF BIRTH	
MARY ELIZABETH FRALEY				FEMALE		CAUCASIAN		APRIL 23, 1904	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		6. AGE (IN YEARS LAST BIRTHDAY)		9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		USA				75		MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BETHESDA		NATIONAL NAVAL MEDICAL CENTER		Housewife		Home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MARYLAND		MONTGOMERY		SILVERSPRING		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4 BRIGGS COURT	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
ARCHIE WILLIS EADER		MARGRET NMN GARTNER		NO		213-74-3874		MARY F. DRIVER 4 BRIGGS CT SILVER SPRING MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). PNEUMONITIS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
486- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF COMPLICATING SUBDURAL HEMATOMA (c) DUE TO, OR AS A CONSEQUENCE OF									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
Michael W. Meriwether MD								3/23/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
Michael W. Meriwether MD						Dept. Neurosurgery / NME / Bethesda, Md. 20014			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
Burial		3/25/80		Arlington National Cemetery		Arlington, Virginia			
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland						2085 MAR 28 1980		Dorothy McCready	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																			
1. FOR STATE REGISTRAR		2. DATE OF DEATH				3. REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
LOUISE						FRANKLIN		3/1/80								9:20 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS									
Female		Caucasian		Jan. 23 1904		76		YRS.		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Virginia		U.S.A.				MONTGOMERY										MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
BETHESDA		SUBURBAN HOSPITAL		Cook		Restaurant													
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. COUNTY		13d. CITY OR TOWN		13e. INSIDE CITY LIMITS?		13f. STREET ADDRESS									
Maryland		Montgomery		Gaithersburg		Yes <input checked="" type="checkbox"/> NO <input type="checkbox"/>				927 Clopper Road									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Robert		David		Crouch		Mary				Markham									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		226 03 7652		George Franklin		same as item 13													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4280										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure										24 hrs.									
DUE TO, OR AS A CONSEQUENCE OF (c) long-standing																			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) (b) lower lobe pneumonitis																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
		HOUR A.M. MONTH DAY YEAR																	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION															
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		STREET		CITY OR TOWN		COUNTY		STATE									
22. I certify that (I) (this hospital) attended the deceased from February 28, 1980, to March 1, 1980, that (I) (we) most saw the deceased alive on March 1, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE		DEGREE		22c. DATE SIGNED															
James E. Wilson, Jr. M.D.				3/1/80															
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																	
James E. Wilson, Jr. M.D.		11125 Rockville Pike, Rockville, Md. 20852																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE									
Burial		3/5/80		Ft. Hill Mem. Park - Lynnhur		CITY OR TOWN		COUNTY		STATE									
24. FUNERAL DIRECTOR		24b. NAME		24c. ADDRESS		24d. DATE REC'D. BY REGISTRAR		24e. REGISTRAR'S SIGNATURE											
ROBERT A. PUMPHREY		HOMES, P.A., ROCKVILLE, MARYLAND				MAR 5 1980													

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07812

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Elsie		Nolan		Friedman				3-30		19		80				AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Female	Caucasian	June 22, 1902		27 YRS.				March 30, 1980								11 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH										MD.	
Virginia		USA				Montgomery											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Chevy Chase		3412 Bradley Lane		French Prof./Translator Teaching													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS									
Md.		Montgomery		Chevy Chase				3412 Bradley Lane									
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST							
Frederick		Nolan				Emily		Batkins									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
no		215 72 7147		Joseph R. Friedman		see # 13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
179- Metastatic Carcinoma																	
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		(b) Carcinoma of Uterus		DUE TO, OR AS A CONSEQUENCE OF													
		(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion		death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		MEDICAL EXAMINER											
John G. Ball		M.D. Deputy		March 30, 1980													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
John G. Ball, MD		7936 Old Georgetown Rd., Beth, Md															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Cremation		3/31/80		Cedar Hill Crematory		Suitland, Maryland P.G.											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE											
Joseph Gawler's Sons		5130 Wisc. Av., NW		Wash. D.C.		APR 7 1980											

1980

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x

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1980

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. IF THE DELAY IS MORE THAN 24 HOURS, THE EXAMINER MUST WRITE "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME, AND PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. IF THE DELAY IS MORE THAN 72 HOURS, THE EXAMINER MUST WRITE "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME, AND PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. IF THE DELAY IS MORE THAN 72 HOURS, THE EXAMINER MUST WRITE "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME, AND PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 07813	
1. DECEASED NAME (TYPE OR PRINT) Charles William Fuller, Sr.										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 3/25 1980										2b. HOUR 5:30 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Mar. 26, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD 3/25 1980		2d. HOUR 5:30 AM							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.									
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4616 Aspen Hill Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired				12b. KIND OF BUSINESS OR INDUSTRY Union									
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4616 Aspen Hill Road											
14. FATHER'S NAME FIRST MIDDLE LAST William B. Fuller				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lola Putman																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. none				17. INFORMANT ADDRESS Virginia Fuller-wife-(same as 13e)													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial disease DUE TO, OR AS A CONSEQUENCE OF (b) rheumatic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) 3989 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Diabetes mellitus																					
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE John S. Rogers, M.D.				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER				DATE SIGNED 3/25/80									
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3-28-1980		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.											
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md. King Brohawn																					

MAR 31 1980

REGISTER'S SIGNATURE **Robert M. Brady**

Charles William Fuller

x

Silver Spring 10 to 12th Hill Road

Landmark: Silver Spring 10 to 12th Hill Road

How's your business?

Business is good.

Business is good.

One

One

x

x

1/25/50

1111 11th Street, N.W.
Washington, D.C.

John J. Rogers, Jr.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 07814	
1- STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) William L. Fyock						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 3 DAY 25 YEAR 1980			2b. HOUR M 1:26A				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 3, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 25 1980			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired					
12b. KIND OF BUSINESS OR INDUSTRY Bd. of Ed.				13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville			
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 1609 Coral Sea Drive									
14. FATHER'S NAME FIRST MIDDLE LAST Jerome D. Fyock						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriet Lewis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 579 30 9914		17. INFORMANT ADDRESS Rose M. Fyock same as 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4169 IMMEDIATE CAUSE (a) Cor pulmonale DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE [Signature]				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 3/26/80					
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St. Balto., MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3/29/80		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park				23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland			
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR APR 2 1980				25b. REGISTRAR'S SIGNATURE [Signature]					
1331 Rockville Pike Rockville, Maryland 20852													

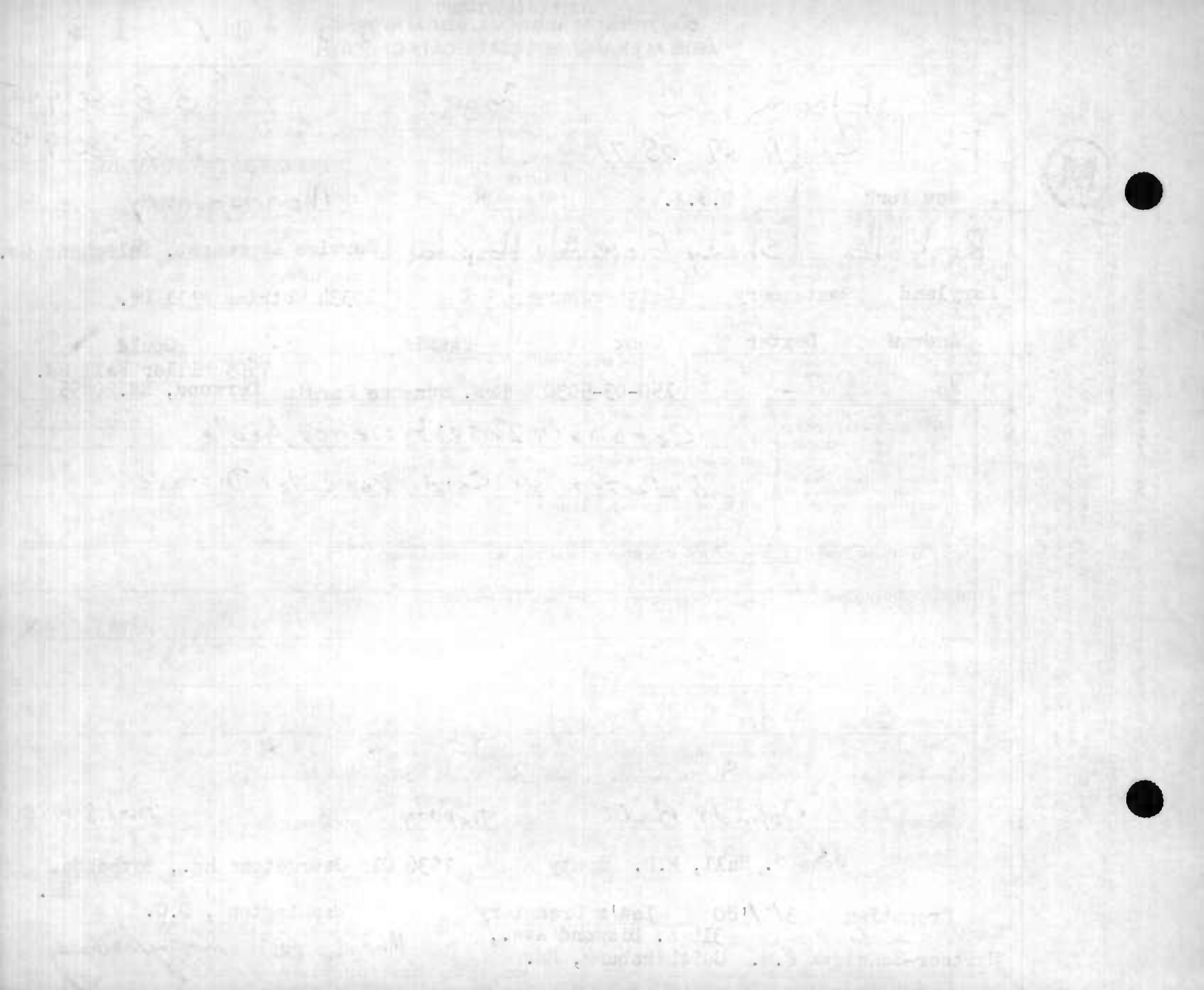
...continued...

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (1))
15M 7/76

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										07815 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Elnora C. Gage						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/>		MONTH DAY YEAR 3 8 1980		7b. HOUR 9 45 M	
3. SEX F		4. RACE C.		5. DATE OF BIRTH MONTH DAY YEAR 11 29 08 71 YRS.		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN. 7 1		7c. DATE PRONOUNCED DEAD 3 8 1980		7d. HOUR 9 45 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York				7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Rockville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adv Hospital				12a. USUAL OCCUPATION (FOR MOST OF WORKING LIFE) Service Represent. Telephone Co.		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10334 Watkins Mill Dr.			
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Dexter Cook						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie - Gould					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 150-03-5030				17. INFORMANT ADDRESS Mrs. Suzanne Hardin 7505 Miller Fall Rd. Derwood, Md. 20855			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency Acute DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 411- Hypertensive Cardiovascular Disease (b) Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) Deputy M.D.				DATE SIGNED March 8, 1980			
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D. Deputy				ADDRESS 7936 Old Georgetown Rd., Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 3/9/80		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME Gartner-Sandison				316 E. Diamond Ave., Gaithersburg, Md.				25a. DATE REC'D. BY REGISTRAR MAR 10 1980			
								25b. REGISTRAR'S SIGNATURE John G. Ball			

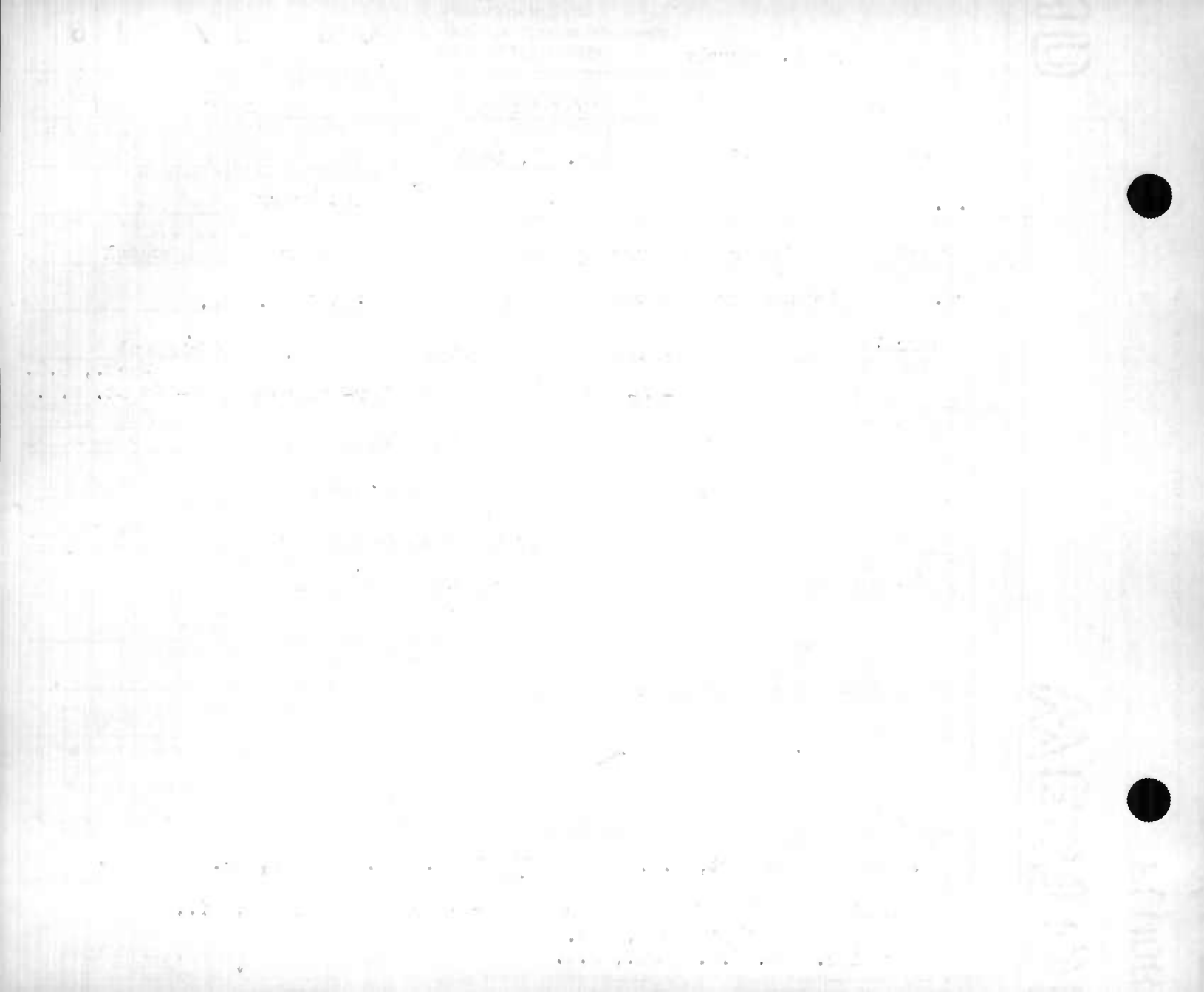


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR		Agnes F. Garrels		CERTIFICATE OF DEATH		REG. NO. 0 0 7 8 1 6			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Agnes F. GARRELS					2a. DATE OF DEATH MONTH DAY YEAR 3 20 80			2b. HOUR A 759 M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Nov. 23, 1890		6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY School	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11901 Ga. Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Garrels					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriet E. (Unknown)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-60-0699		17. INFORMANT ADDRESS Frank Strickler-Attorney 1050-17th St. N.W. Wash., D.C.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary embolism DUE TO, OR AS A CONSEQUENCE OF (b) Venous thrombosis, right leg DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 minutes 17 days 20 to 30 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): arteriosclerotic cardiac disease, severe osteoarthritis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from April 19, 78 to March 20, 1980 , that (I) (we) last saw the deceased alive on March 1, 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. Stephen Hulburt, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED Mar. 20, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Stephen Hulburt, M.D.				22e. ADDRESS 11901 Ga. Ave. Wheaton, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/22/80		23c. NAME OF CEMETERY OR CREMATORY Gedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md.			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisc. Ave. N.W. Wash., D.C.						25a. DATE REC'D. BY REGISTRAR MAR 27 1980		25b. REGISTRAR'S SIGNATURE Kristy McCready	



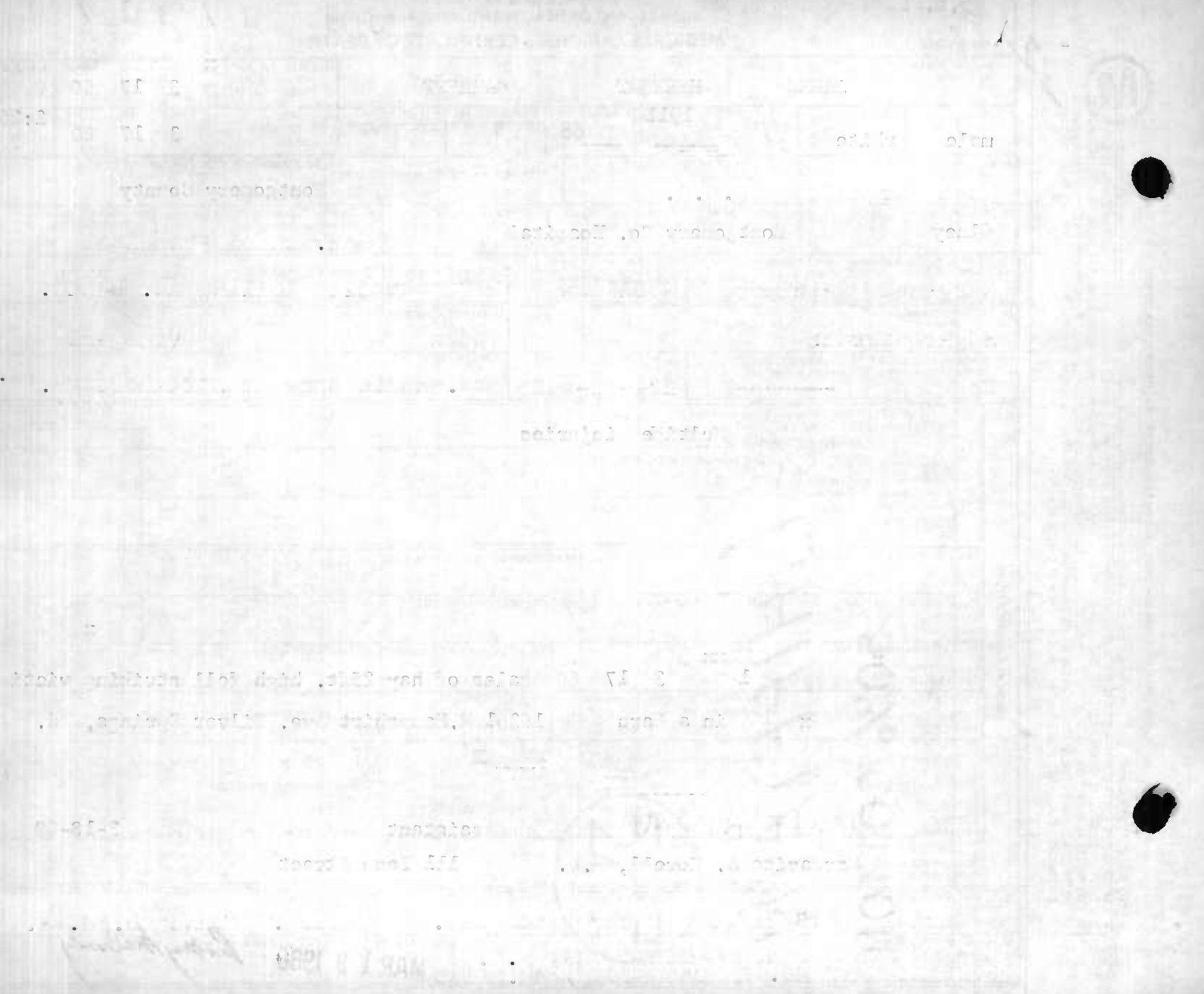
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DHMH - 17
(VR A15 ME (5))
15M 7/77

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH	DAY	YEAR	2b. HOUR
JAMES HERBERT GARRETT									3 17 80		19			M
1. SEX	4. RACE	3. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. TIME			
male	white	3/30/1910	69	88		3 17 80		19			2:26 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH						
West Virginia		U.S.A.		WIDOWED		DIVORCED		Montgomery County		MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Olney		Montgomery Co. Hospital								Ret. School Principal				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		21207				
Maryland		Baltimore		Woodlawn		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3216 Rolling Rd.		Balt.				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME									
Edgar Garrett					Losa Vineyard									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS				
No					234-22-9965					Mrs. Maudie Garrett Baltimore Md. 21207				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I DEATH WAS CAUSED BY: Multiple injuries														
IMMEDIATE CAUSE (a) 916- } DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							20. AUTOPSY?				
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
1 P.M. 3 17 80			1 P.M. 3 17 80			bales of hay 25ft. high fell striking victim								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION								
			in a barn			19301 N. Hampshire Ave. Silver Springs, Md.								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE			TITLE (SPECIFY)							DATE SIGNED				
Margarita A. Korell, M.D.			Assistant							3-18-80				
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS											
Margarita A. Korell, M.D.			111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN			COUNTY STATE			
Burial			3/21/80		Rockybranch Cem.			Walton.			Roane Co. W. Va.			
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
LORING BYERS FUNERAL DIRECTORS, P.A.										MAR 19 1980		[Signature]		
8728 LIBERTY RD. RANDALLSTOWN, MD. 21133														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 should be filed within 72 hours after death. The medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Rebecca Wire Gault					2a. DATE OF DEATH MONTH DAY YEAR 3-13-80					2b. HOUR 535 P
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 1/4/15		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Bookkeeping		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST J. Franklin Wire					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Hall					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-20-2525A		17. INFORMANT ADDRESS The Rev. Dr. Edward S. Gault, same as #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEART CONGESTIVE HEART FAILURE 3989 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Rheumatic heart disease; Atrial fibrillation, peripheral arterial disease DUE TO, OR AS A CONSEQUENCE OF (c) Peripheral arterial emboli APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 DAYS YRS. 4 DAYS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Acute renal failure										
19a. DATE OF OPERATION 3/10/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED acute arterial occlusion (both legs)				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from 3/10 19 80, to 3/13 19 80, that (I) (we) last saw the deceased alive on 3/13 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.										
22b. SIGNATURE Louis Kozloff				DEGREE MD				22c. DATE SIGNED 3/14/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis Kozloff, MD				22e. ADDRESS 8218 WISCONSIN AVE. BETHESDA, MD. 20014						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/17/80		23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland				
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. 300 West Montgomery Ave., Rockville, MD				25a. DATE AND D. BY REGISTRAR MAR 11 1980		25b. REGISTRAR'S SIGNATURE [Signature]				

Date

No.

Name

Address

City

State

Country

Telephone

Post Office

Name

Address

City

State

No.

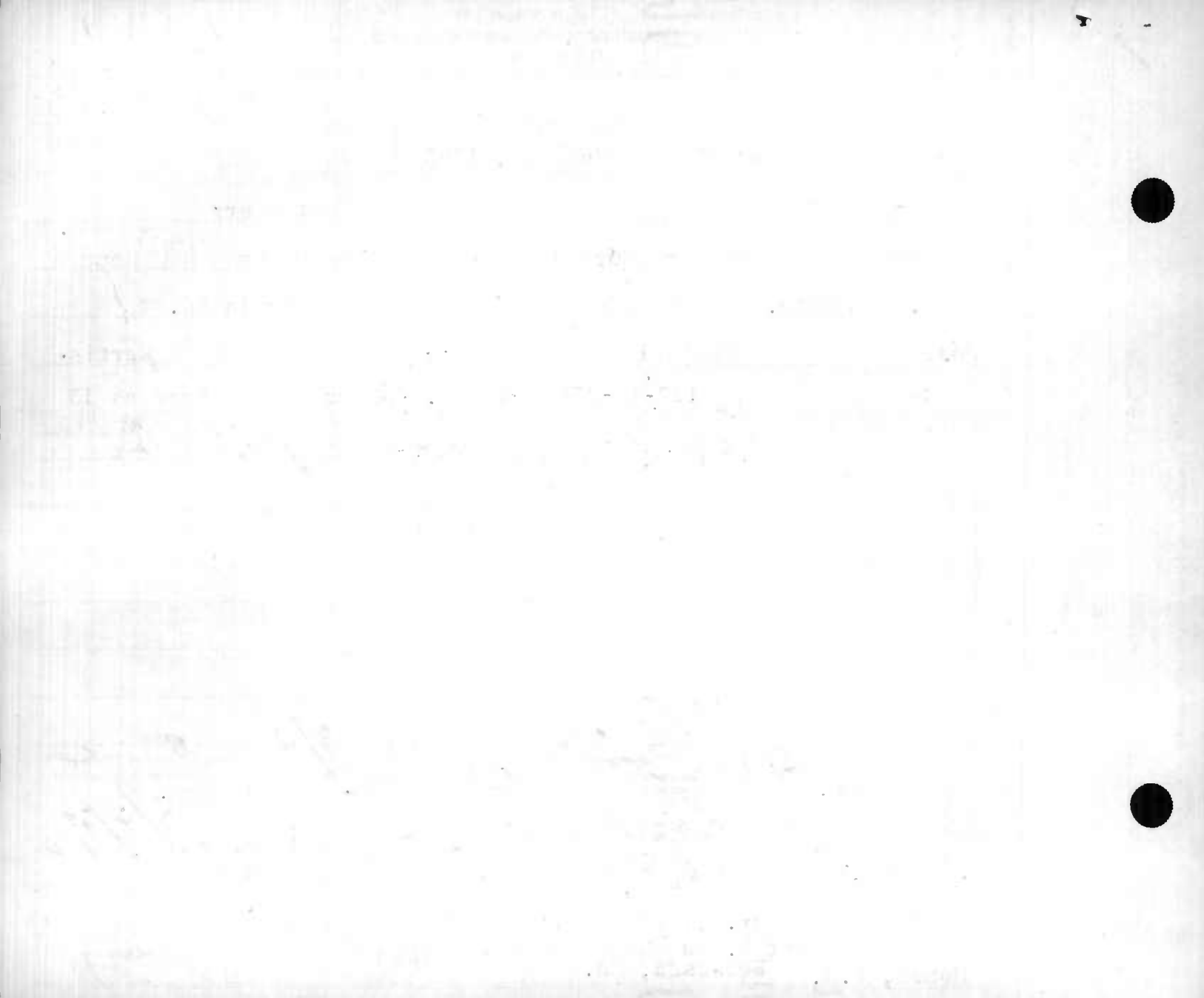
U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

WASHINGTON, D. C. 20250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO.		07819						
1. DECEASED NAME (TYPE OR PRINT) EMMA			FIRST MIDDLE LAST BAYDOS			2a. DATE OF DEATH MONTH DAY YEAR 3 4 80		2b. HOUR MIN 12 40 P.M.		
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 26, 1893		6 AGE (IN YEARS LAST BIRTHDAY) 86		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Austria-Hungary		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10 CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Md.			13b. COUNTY Montg.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5604 Durbin Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Remiski			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Kertis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO 127-10-2760		17 INFORMANT ADDRESS Irene E. Onderchek Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Due to, or as a consequence of</u> (c) <u>Due to, or as a consequence of</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):										
MEDICAL CERTIFICATION										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that (I) (this hospital) attended the deceased from 3/3 to 3/4 1980, that (I) last saw the deceased alive on 3/4 1980, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										
23. SIGNATURE Myron L. Lenkin				DEGREE		24. DATE SIGNED 3/4/80				
24. PHYSICIAN'S NAME (TYPE OR PRINT) MYRON L. LENKIN				25. ADDRESS 2309 SHOREFIELD RD WHEATON MD						
26a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		26b. DATE Mar. 7, 1980		26c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		26d. LOCATION CITY OR TOWN COUNTY STATE Queens New York				
27. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A.				28. DATE REC'D. BY REGISTRAR MAR 10 1980		29. REGISTRAR'S SIGNATURE [Signature]				

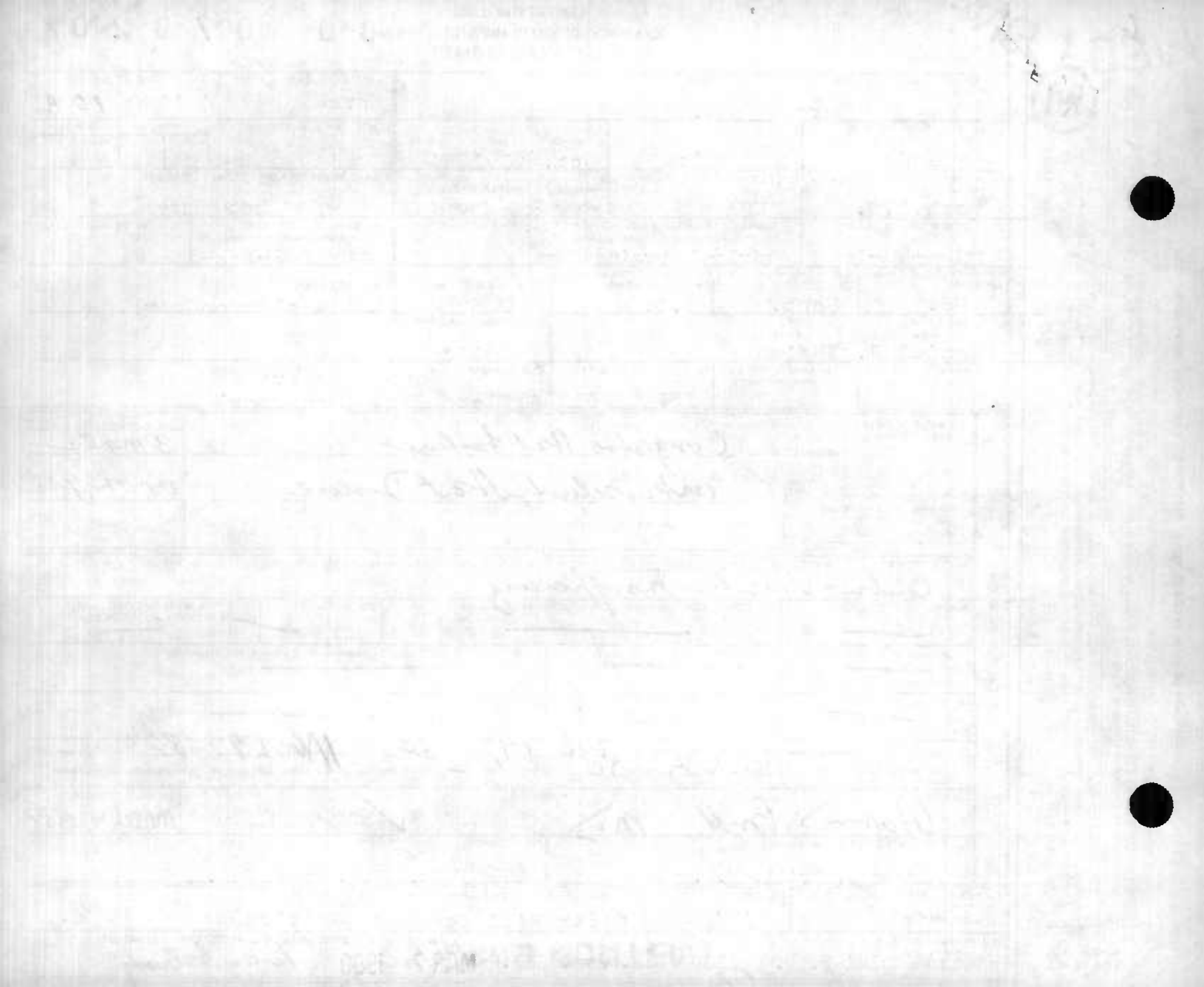


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR	
Mary T. Gebicke						March			4 1980		10 A M	
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR		7 UNDER 24 HRS	
Female		White		Oct. 21, 1894			85 YRS		MONTHS		DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH					
Wash. D.C.		USA					Montgomery MD.					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring			Fairland Nursing Home			PBX Operator						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.			Mont.		S.S.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1018 Hollywood Ave.			
14 FATHER'S NAME						15 MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST						FIRST MIDDLE LAST						
Daniel J. Whalen						Alice E. Daley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO.		17 INFORMANT				
None						577 03 5184		Same as above				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>										3 months		
4140												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										or one year		
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
<u>Cerebro-Vascular Insufficiency</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
			HOUR AM MONTH DAY YEAR									
			P.M. 19									
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION						
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from <u>Feb. 15, 1980</u> , to <u>March 4, 1980</u> , that (I) (we) last saw the deceased alive on <u>March 3, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE						DEGREE			22c. DATE SIGNED			
<u>Warren D. Brill M.D.</u>									MARCH 4, 1980			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS						
Warren D. Brill, M.D.						2000 N St., N.W. Wash. D.C. 20036						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION		COUNTY STATE		
Burial			3/7/80		Cedar Hill Cemetery Suitland			PG		Md.		
24 FUNERAL DIRECTOR												
NAME ADDRESS												
Hines/Rinaldi F. H. 11800 N.H. Ave., Sil. Sp. Md.												
25a. DATE REC'D. BY REGISTRAR												
MAR 7 1980												
25b. REGISTRAR'S SIGNATURE												
<u>John A. Brady</u>												



1551 Rockville Pike Rockville, Md. 20852
 Yvon Wheeler Thermal Lome, Inc.
 Creation 3-30-80 Metropolitan Observatory Alexandria Virginia
 10400 Conn. Ave. Kensington, Maryland

Yes Rank Gentilini Maria Tobias
 W II 092 07 8252 Mary R. Gentilini Same as item 13-a

M.B. (unpublished) 10105 Fairbairn Ave.
 Bethesda Suburban Publishing
 New York U.S.A. XX

1551 Rockville Pike Rockville, Md. 20852
 Yvon Wheeler Thermal Lome, Inc.
 Creation 3-30-80 Metropolitan Observatory Alexandria Virginia
 10400 Conn. Ave. Kensington, Maryland

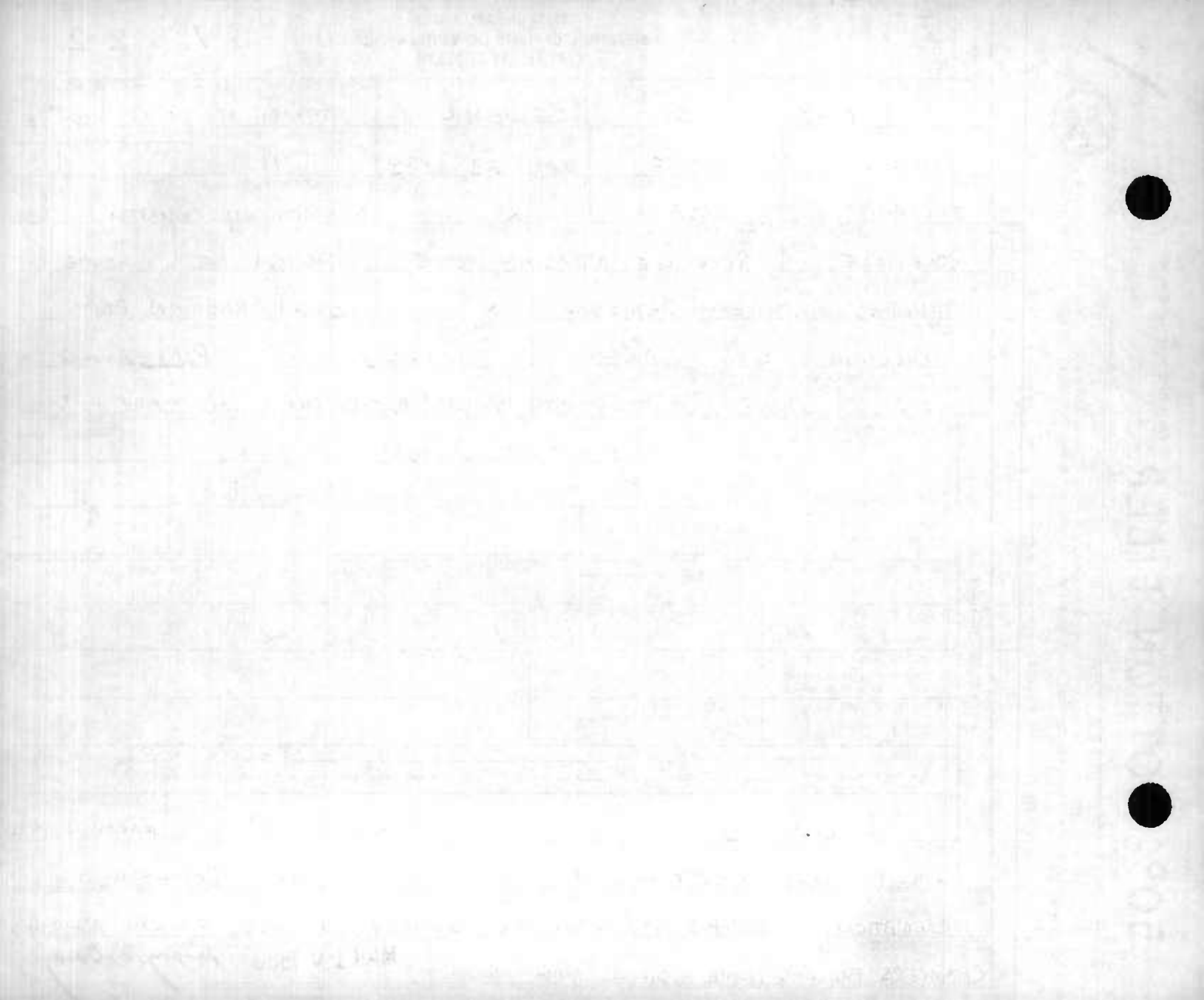
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																																	
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				2b. HOUR																											
1. DECEASED NAME (TYPE OR PRINT)		3. SEX				4. RACE				5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
MAE S. GEWEHR		FEMALE		WHITE		MAY 23, 1888		91 YRS		ILLINOIS		USA.				MONTGOMERY COUNTY MD.																	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT							
ROCKVILLE		ROCKVILLE, NURSING HOME		HOUSEWIFE		HOME		5021 RODMAN ROAD		MONTGOMERY		BETHESDA		YES		5021 RODMAN ROAD		WILLIAM S. SANSOM		MAGGIE - PICKERING		NO		579-50-2449		HAMILTON D. GEWEHR (SON)							
18. CAUSE OF DEATH		PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		b)		DUE TO, OR AS A CONSEQUENCE OF		c)		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
1749		1749		cardiac arrest		Coronary (heart)		2 years																									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)							
1977		Ca breast		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN		COUNTY		STATE		4-19-1977		March 4, 1980		DR. FRAUKE WESTPHALL, M.D.					
22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. NAME OF CEMETERY OR CREMATORY		22g. LOCATION		22h. COUNTY		22i. STATE		22j. NAME OF CEMETERY OR CREMATORY		22k. LOCATION		22l. COUNTY		22m. STATE		22n. NAME OF CEMETERY OR CREMATORY		22o. LOCATION					
2-25-1980		Frankie Westphall M.D.		MARCH 4, 1980		DR. FRAUKE WESTPHALL, M.D.		5104 WICKETT TERR. BETHESDA, MD.		CEDAR HILL CREMATORY		SUITLAND		P.G.CO.		MARYLAND		CEDAR HILL CREMATORY		SUITLAND		P.G.CO.		MARYLAND		CEDAR HILL CREMATORY		SUITLAND					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY		23f. STATE		23g. NAME OF CEMETERY OR CREMATORY		23h. LOCATION		23i. COUNTY		23j. STATE		23k. NAME OF CEMETERY OR CREMATORY		23l. LOCATION		23m. COUNTY		23n. STATE							
CREMATION		MARCH 5, 1980		CEDAR HILL CREMATORY		SUITLAND		P.G.CO.		MARYLAND		CEDAR HILL CREMATORY		SUITLAND		P.G.CO.		MARYLAND		CEDAR HILL CREMATORY		SUITLAND		P.G.CO.		MARYLAND							
24. FUNERAL DIRECTOR		24a. NAME		24b. ADDRESS		24c. DATE		24d. BY REGISTRAR		24e. REGISTRAR'S SIGNATURE		24f. DATE		24g. BY REGISTRAR		24h. REGISTRAR'S SIGNATURE		24i. DATE		24j. BY REGISTRAR		24k. REGISTRAR'S SIGNATURE		24l. DATE		24m. BY REGISTRAR							
CHAMBERS FUNERAL HOME - SILVER SPRING, MD.		CHAMBERS FUNERAL HOME - SILVER SPRING, MD.		CHAMBERS FUNERAL HOME - SILVER SPRING, MD.		CHAMBERS FUNERAL HOME - SILVER SPRING, MD.		CHAMBERS FUNERAL HOME - SILVER SPRING, MD.		CHAMBERS FUNERAL HOME - SILVER SPRING, MD.		CHAMBERS FUNERAL HOME - SILVER SPRING, MD.		CHAMBERS FUNERAL HOME - SILVER SPRING, MD.		CHAMBERS FUNERAL HOME - SILVER SPRING, MD.		CHAMBERS FUNERAL HOME - SILVER SPRING, MD.		CHAMBERS FUNERAL HOME - SILVER SPRING, MD.		CHAMBERS FUNERAL HOME - SILVER SPRING, MD.		CHAMBERS FUNERAL HOME - SILVER SPRING, MD.		CHAMBERS FUNERAL HOME - SILVER SPRING, MD.							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 07823	
1. DECEASED NAME (TYPE OR PRINT) Sadie Cecelia Gilbertson										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 3/17 1980	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH Jan DAY 24 YEAR 1897	6. AGE (IN YEARS) LAST BIRTHDAY 83 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN 0	IF UNDER 24 HRS. MONTHS 0 DAYS 0 HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD 3/17 1980		2b. HOUR P. 20			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WISCONSIN		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) 3431 S. Leisure World Blvd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS #1-B 3431 S. Leisure World Blvd.			
14. FATHER'S NAME FIRST OLE MIDDLE PAULSON LAST PAULSON		15. MOTHER'S MAIDEN NAME FIRST LOVISE MIDDLE TILLESON LAST TILLESON		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 473-52-6700		17. INFORMANT DAUGHTER ADDRESS 1403 SARAH DRIVE SILVER SPRING, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial disease. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers, M.D.		TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 3/17/80					
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.		ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/21/80		23c. NAME OF CEMETERY OR CREMATORY FT. SNELLING NATIONAL		23d. LOCATION CITY OR TOWN FT. SNELLING COUNTY MINNESOTA STATE					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		25a. DATE REC'D. BY REGISTRAR MAR 21 1980		25b. REGISTRAR'S SIGNATURE Robert McCreedy							
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											

2002

03-2287

Results

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

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bio. marina? 8/91
no. 1, 1990, 2000

14-00000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____
DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 0 7 8 2 4

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD L. GOBIN			2a. DATE OF DEATH MONTH DAY YEAR MARCH 26, 80			2b. HOUR 10:00 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUN. 6 - 1891		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FAIRLAND NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FED. GOVT. (RET)		12b. KIND OF BUSINESS OR INDUSTRY	

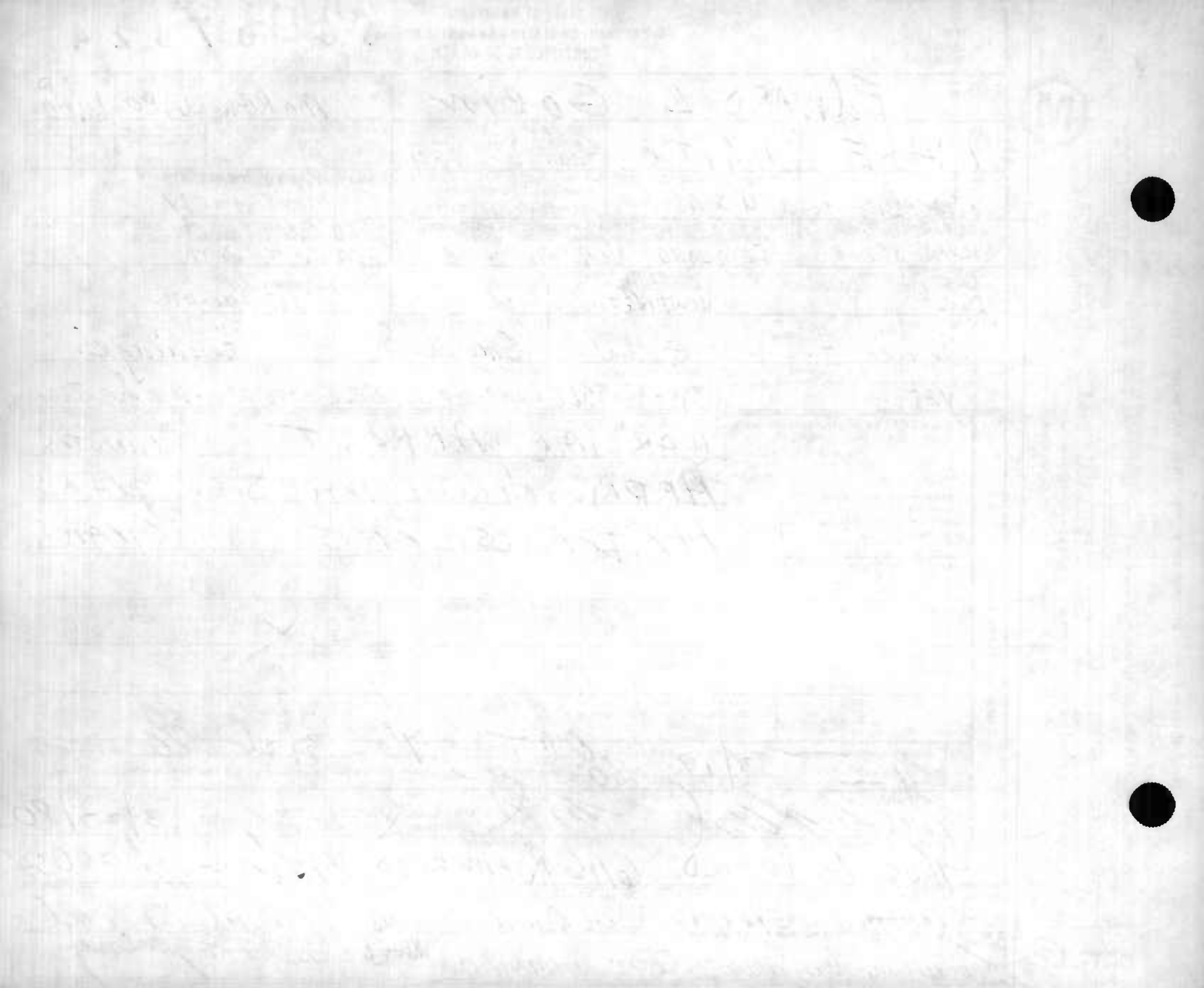
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C.		13b. COUNTY WASHINGTON		13c. CITY OR TOWN WASHINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Not Known	
14. FATHER'S NAME FIRST MIDDLE LAST Charles H. GOBIN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emelia S. Henninger					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-38-7560		17. INFORMANT ADDRESS LAWRENCE L. BELL, ATT. 7101 WIS. AVE BETH.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DIS. DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES YEARS YEARS	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) this hospital attended the deceased from OCT 76 to 3/26 80 , that (I) was last saw the deceased alive on 3/19 80 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) will (did not) view the body after death.							
22a. SIGNATURE Thos G. Inard		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/27/80	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. INARD		22d. ADDRESS 6116 ROBIN WOOD, BETHESDA, MD 20034					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 3/27/1980		23c. NAME OF CEMETERY OR CREMATORY Fair Lincoln Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Bethesda MD	
24. FUNERAL DIRECTOR NAME Tabor Funeral Home, J.A. Walters		ADDRESS 254 Chesa Rd NW DC		25. DATE REC'D. BY REGISTRAR MARCH 1 1980		25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HENRIETTA W. GOLDBERG			2a. DATE OF DEATH MONTH DAY YEAR March 30, 1980			2b. HOUR 1:40 A			
3. SEX Female		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR Mar. 22, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood Nursing Center				12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Texas		13b. COUNTY Dallas		13c. CITY OR TOWN Dallas		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7867 Willow Hill Court	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Wolf				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Miriam Gretzner				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16a. SOCIAL SECURITY NO. 467-24-2342				17. INFORMANT Jerald M. Goldberg				17b. ADDRESS 2844 Wisc. Ave. #910 Wash, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BREAST CANCER - METASTATIC</u> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 YRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 19 79</u> to <u>MARCH 4, 1980</u> , that (I) (we) last saw the deceased alive on <u>MARCH 29, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Allen M. Mondzac</u>						DEGREE M.D.		22c. DATE SIGNED 3/30/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Allen M. Mondzac M.D.						22e. ADDRESS 10409 Logan Dr. Potomac, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Apr 2, 1980		23c. NAME OF CEMETERY OR CREMATORY Temple Emanuel Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Dallas Dallas Texas		
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG CHAPELS			ADDRESS ROCKVILLE MD.			25a. DATE REC'D. BY REGISTRAR APR 3 1980		25b. REGISTRAR'S SIGNATURE <u>John H. Brady</u>	

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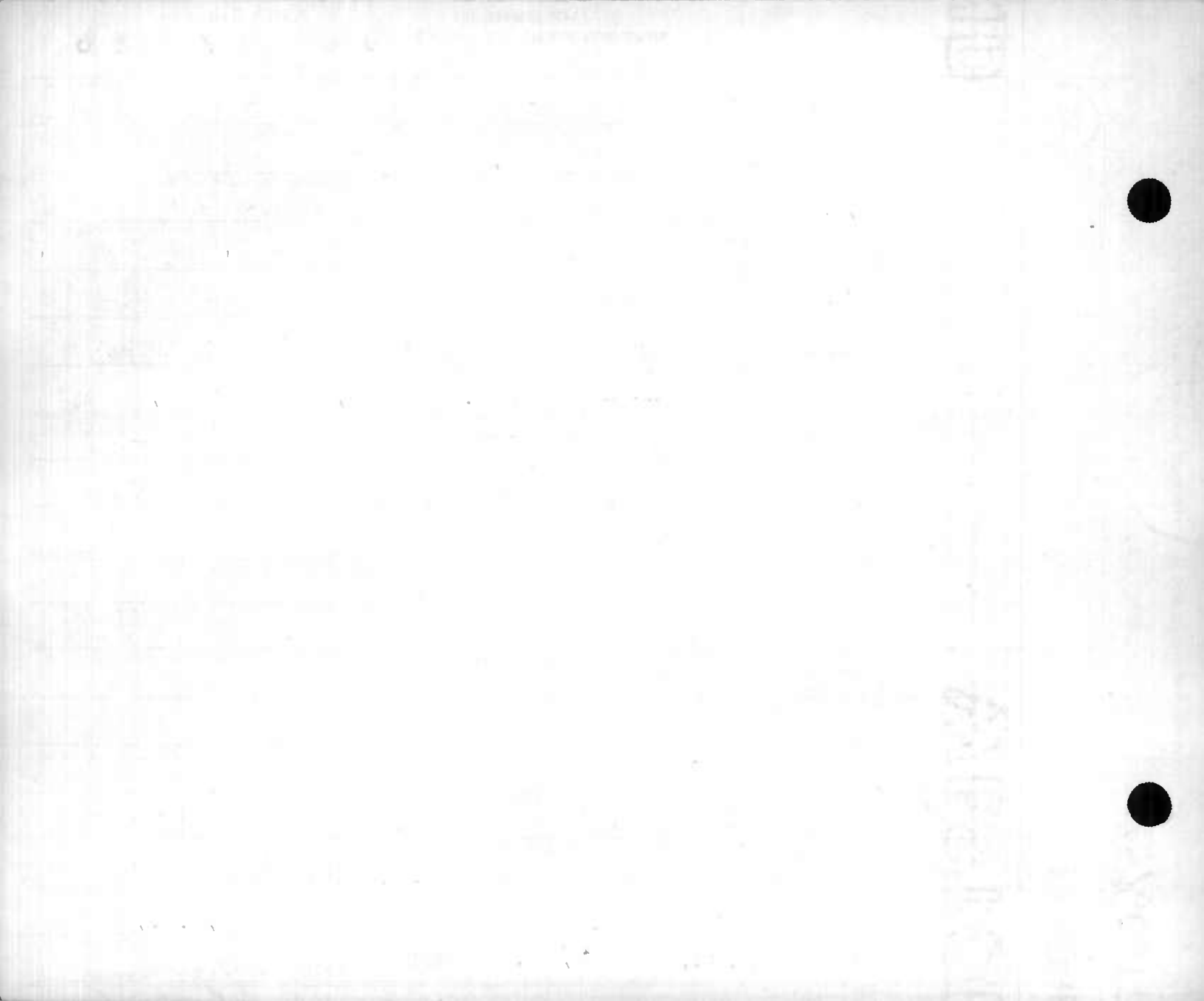
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Approved by Medical Examiner

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 60 07826	
1. DECEASED NAME (TYPE OR PRINT) MARVIN IRWIN GOLDBERG					2a. DATE OF DEATH MONTH DAY YEAR 3 77 880			2b. HOUR 4 12 AM			
3 SEX MALE		4 RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MARCH 7, 1920		6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SYSTEMS ACC'TANT		12b. KIND OF BUSINESS OR INDUSTRY US GOV'T			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 13139 BEAVER TERRACE			
14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM - - GOLDBERG					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH (UNKNOWN)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17 INFORMANT ADDRESS MRS. KEMELHOR, 6211 REDWING, BETHESDA							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac standstill</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>cardiogenic shock</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>acute myocardial infarction</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 8 hrs 10 hrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from <u>3-7</u> , 19 <u>80</u> , to <u>3-7</u> , 19 <u>80</u> , that (we) lost saw the deceased alive on <u>3-7</u> , 19 <u>80</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Thomas G. Sindereson, MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3-7-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS G. SINDERESON, MD					22e. ADDRESS 11125 ROCKVILLE PIKE, ROCKVILLE, Md. 20852						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/9/80		23c. NAME OF CEMETERY OR CREMATORY MT. LEBANON		23d. LOCATION CITY OR TOWN COUNTY STATE HYATTSVILLE, P.G., MD					
24 FUNERAL DIRECTOR DANZANSKY-GOLDBERG MEM. CH., ROCKVILLE, MD.					25a. DATE REC'D. BY REGISTRAR MAR 13 1980		25b. REGISTRAR'S SIGNATURE [Signature]				



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or any traumatic event, the medical examiner must be notified of this.

Cleared by Chasen Dr. Rogers

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 0 0 7 8 2 7							
1. DECEASED NAME (TYPE OR PRINT) Warren				FIRST MIDDLE LAST Goldmann		2a. DATE OF DEATH MONTH DAY YEAR March 3 1980		2b. HOUR 0645A.M.	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 4 13 1915		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Consulting Engr. U.S. Gov't		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Francis Goldmann				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline Spitz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 058-07-6596		17. INFORMANT ADDRESS Lucille V. Goldmann same as 13c					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac arrest</u> 431- DUE TO, OR AS A CONSEQUENCE OF (b) <u>right thalamic hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 4 days 20 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2/28/80</u> to <u>3/3/80</u> , that (I) (we) last saw the deceased alive on <u>3/2/80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If you (we) did not view the body after death, so state.)									
22b. SIGNATURE Mark S. Rosen MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/3/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark S. Rosen, M.D.				22e. ADDRESS 1131 Univ. Blvd. W. Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/6/80		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR MAR 4 1980		25b. REGISTRAR'S SIGNATURE Anthony McVerry			

38

IN THE
COURT OF THE COMMON PLEAS
FOR THE COUNTY OF MIDDLESEX

IN SENATE

1911-1912

1911-1912

1911-1912

1911-1912

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 0 7 8 2 8			
1- FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) EVA GOLDSTEIN				2a DATE OF DEATH MONTH DAY YEAR March 18, 1980		2b HOUR 2:35 A.M.	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR August 29, 1989		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS. MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Home	
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Aaron Harry Weinberg		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Clar		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 579-50-2787	
17 INFORMANT Harry Goldstein		18 ADDRESS 6916 Western Ave. Chevy Chase		19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3-17-80 P.M. 19	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 3-17-80 to 3-18-80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b SIGNATURE Herbert L. Tanenbaum DEGREE		22c DATE SIGNED 3/18/80		22d PHYSICIAN'S NAME (TYPE OR PRINT) Herbert L. Tanenbaum M.D.	
22e ADDRESS 5480 Wisconsin Ave. Chevy Chase, Md.		23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 3-19-80		23c NAME OF CEMETERY OR CREMATORY Tifereth Israel	
23d LOCATION CITY OR TOWN Washington, D. C.		23e NAME OF CEMETERY OR CREMATORY Washington, D. C.		23f LOCATION CITY OR TOWN Washington, D. C.		23g COUNTY D. C.	
23h STATE D. C.		23i NAME OF CEMETERY OR CREMATORY Washington, D. C.		23j LOCATION CITY OR TOWN Washington, D. C.		23k COUNTY D. C.	
23l STATE D. C.		23m NAME OF CEMETERY OR CREMATORY Washington, D. C.		23n LOCATION CITY OR TOWN Washington, D. C.		23o COUNTY D. C.	
23p STATE D. C.		23q NAME OF CEMETERY OR CREMATORY Washington, D. C.		23r LOCATION CITY OR TOWN Washington, D. C.		23s COUNTY D. C.	
23t STATE D. C.		23u NAME OF CEMETERY OR CREMATORY Washington, D. C.		23v LOCATION CITY OR TOWN Washington, D. C.		23w COUNTY D. C.	
23x STATE D. C.		23y NAME OF CEMETERY OR CREMATORY Washington, D. C.		23z LOCATION CITY OR TOWN Washington, D. C.		23aa COUNTY D. C.	
23ab STATE D. C.		23ac NAME OF CEMETERY OR CREMATORY Washington, D. C.		23ad LOCATION CITY OR TOWN Washington, D. C.		23ae COUNTY D. C.	
23af STATE D. C.		23ag NAME OF CEMETERY OR CREMATORY Washington, D. C.		23ah LOCATION CITY OR TOWN Washington, D. C.		23ai COUNTY D. C.	
23aj STATE D. C.		23ak NAME OF CEMETERY OR CREMATORY Washington, D. C.		23al LOCATION CITY OR TOWN Washington, D. C.		23am COUNTY D. C.	
23an STATE D. C.		23ao NAME OF CEMETERY OR CREMATORY Washington, D. C.		23ap LOCATION CITY OR TOWN Washington, D. C.		23aq COUNTY D. C.	
23ar STATE D. C.		23as NAME OF CEMETERY OR CREMATORY Washington, D. C.		23at LOCATION CITY OR TOWN Washington, D. C.		23au COUNTY D. C.	
23av STATE D. C.		23aw NAME OF CEMETERY OR CREMATORY Washington, D. C.		23ax LOCATION CITY OR TOWN Washington, D. C.		23ay COUNTY D. C.	
23az STATE D. C.		23ba NAME OF CEMETERY OR CREMATORY Washington, D. C.		23bb LOCATION CITY OR TOWN Washington, D. C.		23bc COUNTY D. C.	
23bd STATE D. C.		23be NAME OF CEMETERY OR CREMATORY Washington, D. C.		23bf LOCATION CITY OR TOWN Washington, D. C.		23bg COUNTY D. C.	
23bh STATE D. C.		23bi NAME OF CEMETERY OR CREMATORY Washington, D. C.		23bj LOCATION CITY OR TOWN Washington, D. C.		23bk COUNTY D. C.	
23bl STATE D. C.		23bm NAME OF CEMETERY OR CREMATORY Washington, D. C.		23bn LOCATION CITY OR TOWN Washington, D. C.		23bo COUNTY D. C.	
23bp STATE D. C.		23bq NAME OF CEMETERY OR CREMATORY Washington, D. C.		23br LOCATION CITY OR TOWN Washington, D. C.		23bs COUNTY D. C.	
23bt STATE D. C.		23bu NAME OF CEMETERY OR CREMATORY Washington, D. C.		23bv LOCATION CITY OR TOWN Washington, D. C.		23bw COUNTY D. C.	
23bx STATE D. C.		23by NAME OF CEMETERY OR CREMATORY Washington, D. C.		23bz LOCATION CITY OR TOWN Washington, D. C.		23ca COUNTY D. C.	
23cb STATE D. C.		23cc NAME OF CEMETERY OR CREMATORY Washington, D. C.		23cd LOCATION CITY OR TOWN Washington, D. C.		23ce COUNTY D. C.	
23cf STATE D. C.		23cg NAME OF CEMETERY OR CREMATORY Washington, D. C.		23ch LOCATION CITY OR TOWN Washington, D. C.		23ci COUNTY D. C.	
23cj STATE D. C.		23ck NAME OF CEMETERY OR CREMATORY Washington, D. C.		23cl LOCATION CITY OR TOWN Washington, D. C.		23cm COUNTY D. C.	
23cn STATE D. C.		23co NAME OF CEMETERY OR CREMATORY Washington, D. C.		23cp LOCATION CITY OR TOWN Washington, D. C.		23cq COUNTY D. C.	
23cr STATE D. C.		23cs NAME OF CEMETERY OR CREMATORY Washington, D. C.		23ct LOCATION CITY OR TOWN Washington, D. C.		23cu COUNTY D. C.	
23cv STATE D. C.		23cw NAME OF CEMETERY OR CREMATORY Washington, D. C.		23cx LOCATION CITY OR TOWN Washington, D. C.		23cy COUNTY D. C.	
23cz STATE D. C.		23da NAME OF CEMETERY OR CREMATORY Washington, D. C.		23db LOCATION CITY OR TOWN Washington, D. C.		23dc COUNTY D. C.	
23de STATE D. C.		23dd NAME OF CEMETERY OR CREMATORY Washington, D. C.		23de LOCATION CITY OR TOWN Washington, D. C.		23df COUNTY D. C.	
23dg STATE D. C.		23dd NAME OF CEMETERY OR CREMATORY Washington, D. C.		23de LOCATION CITY OR TOWN Washington, D. C.		23df COUNTY D. C.	
23dh STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23di STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23dj STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23dk STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23dl STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23dm STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23dn STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23do STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23dp STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23dq STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23dr STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23ds STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23dt STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23du STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23dv STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23dw STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23dx STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23dy STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23dz STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23ea STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23eb STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23ec STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23ed STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23ee STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23ef STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23eg STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23eh STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23ei STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23ej STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23ek STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23el STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23em STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23en STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23eo STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23ep STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23eq STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23er STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23es STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23et STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23eu STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23ev STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23ew STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23ex STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23ey STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23ez STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23fa STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23fb STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23fc STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23fd STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23fe STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23ff STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23fg STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23fh STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23fi STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23fj STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23fk STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23fl STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23fm STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23fn STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23fo STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23fp STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23fq STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23fr STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23fs STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23ft STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23fu STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23fv STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23fw STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23fx STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23fy STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C.		23dg COUNTY D. C.	
23fz STATE D. C.		23de NAME OF CEMETERY OR CREMATORY Washington, D. C.		23df LOCATION CITY OR TOWN Washington, D. C. </			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 0 7 8 2 9

1 - FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) OLIVE V Goodwin			2a DATE OF DEATH MONTH DAY YEAR 3-21-80			2b HOUR 6:15 AM								
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR Jan 17, 1898		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		# UNDER 1 YEAR MONTHS DAYS		# UNDER 24 HRS HOURS MIN.				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD								
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Home						
13a STATE MD			13b COUNTY Pro Georges			13c CITY OR TOWN Hyattsville			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS 4022 Hamilton Street		
14 FATHER'S NAME FIRST MIDDLE LAST W Weeks						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Bowie								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b SOCIAL SECURITY NO. 578 38 6342A			17 INFORMANT ADDRESS Elizabeth F Davis Hyattsville, Md.								

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 5908 Gram Negative Septicemia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Due to, or as a consequence of Pyelonephritis										one week	
(c) Due to, or as a consequence of											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Severe emphysema											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from August 17, 1978 to March 21, 1980 , that (II) (we) last saw the deceased alive on March 20, 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not) view the body after death.											
22b SIGNATURE Martin C. Shargel						DEGREE M.D.			22c DATE SIGNED 3/21/80		
22d PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN C. SHARGEL						22e ADDRESS 3720 FARRAGUT AVE. KENSINGTON MD - 20795					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE Mar 24, 1980		23c NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery			23d LOCATION CITY OR TOWN COUNTY STATE Brentwood Pro Georges Md.			
24 FUNERAL DIRECTOR NAME F. Gaseh's Sons P A						ADDRESS Hyattsville, Md.			25a DATE PROC. BY REGISTRAR OR REGISTRAR'S SIGNATURE MAR 26 1980		

$56 \div 18$

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO.		0 0 7 8 3 0					
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Anna John Gootan</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>3-13-80</i>		2b. HOUR <i>2:45</i> M	
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 15 1925</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>54</i> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Latvia</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.			
10 CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE <i>Md.</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <i>4436 Oaktree Rd., Rockville, Md.</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>John Iskova</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Unknown</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b SOCIAL SECURITY NO. <i>None</i>		17 INFORMANT <i>Adam J. Gootan</i>		ADDRESS <i>4436 Oaktree Rd., Maryland</i>			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Ovary</i> <i>1830</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mths</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <i>3/3</i> , 19 <i>80</i> , to <i>3/12</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>3/12</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>William C. Bruce</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>3/13/80</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>KIRKLAND C. BRUCE</i>				22e ADDRESS <i>1600 Caven Ave Takoma Park, Md 20912</i>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>Mar. 15, 1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington D.C.</i>			
24 FUNERAL DIRECTOR NAME ADDRESS <i>Hines/Rinaldi F.H.-11800 NH Ave. Sil. Spr. Md.</i>				25a DATE REC'D. BY REGISTRAR <i>MAR 17 1980</i>		25b REGISTRAR'S SIGNATURE <i>Anthony McCready</i>			

BP

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100% COTTON YARN

100% COTTON YARN

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				07831 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST Pauline		MIDDLE Gordon		LAST Gordon	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 9-05-14		6. AGE (IN YEARS) LAST BIRTHDAY 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY --	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPR'G		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL -- -- LEVIN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BELLA -- -- BROSILOWSKY		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO -- --		16b. SOCIAL SECURITY NO. 579-16-1426	
17. INFORMANT ADDRESS JACOB GORDON (HUSBAND) SAME ABOVE		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute.</u> 411- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Hypertensive Cardio-Vascular Disease</u> (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion			
ACTUAL SIGNATURE John G. Ball		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED March 6, 1980	
EXAMINER'S NAME (TYPE OR PRINT) JOHN G. BALL		ADDRESS Old Georgetown Rd., Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/9/80		23c. NAME OF CEMETERY OR CREMATORY MT. LEBANON CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE HYATTSVILLE, P.G., MD.	
24. FUNERAL DIRECTOR NAME ADDRESS DANZANSKY-GOLDBERG MEM. CHAPELS, ROCKVILLE, MD.		25a. DATE REC'D BY REGISTRAR MAR 15 1980		25b. REGISTRAR'S SIGNATURE M. J. McBrady			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		REG. NO. 07832							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lewis A. Gray						2a. DATE OF DEATH MONTH DAY YEAR March 11, 1980		2b. HOUR 8:15^{AM}	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR April 1, 1907		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Research	
13a. STATE Maryland		13b. COUNTY Mont. Co.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9570 Fern Hollow Way	
14 FATHER'S NAME FIRST MIDDLE LAST Arthur - Gray		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tirzah - Heller							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Dolores Gray (Wife) Same as # 13.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest 4275 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral Atrophy (c) Pneumonia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH mins - 10 yrs 10 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1976 , to Mar 11 , 19 80 , that (I) (we) last saw the deceased alive on Feb 13 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Stuart Scott				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED March 11, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. STUART SCOTT				22e. ADDRESS 10401 Old Georgetown Rd. Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE March/12/80		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G. Co., Maryland			
24 FUNERAL DIRECTOR NAME Chambers Funeral Home		ADDRESS Silver Spring, Maryland		DATE RECEIVED BY REGISTRAR MAR 14 1980					



March 11, 1960 10:15

Gray

White

72

April 1, 1961

White

White

x

Continuously cloudy

U.S.A.

White

Research

Impress

Collected wood specimens

Technique

9370 from Heller Bay

A

Wetland

Wet. Co.

Marine

Heller

-

Wetland

Wet

-

Marine

Wetland - Heller Bay (110) March 11, 1961

Wet

Marine

March 11, 1961

x

Wetland - Heller Bay (110) March 11, 1961

Wetland - Heller Bay (110) March 11, 1961

Wetland - Heller Bay (110) March 11, 1961

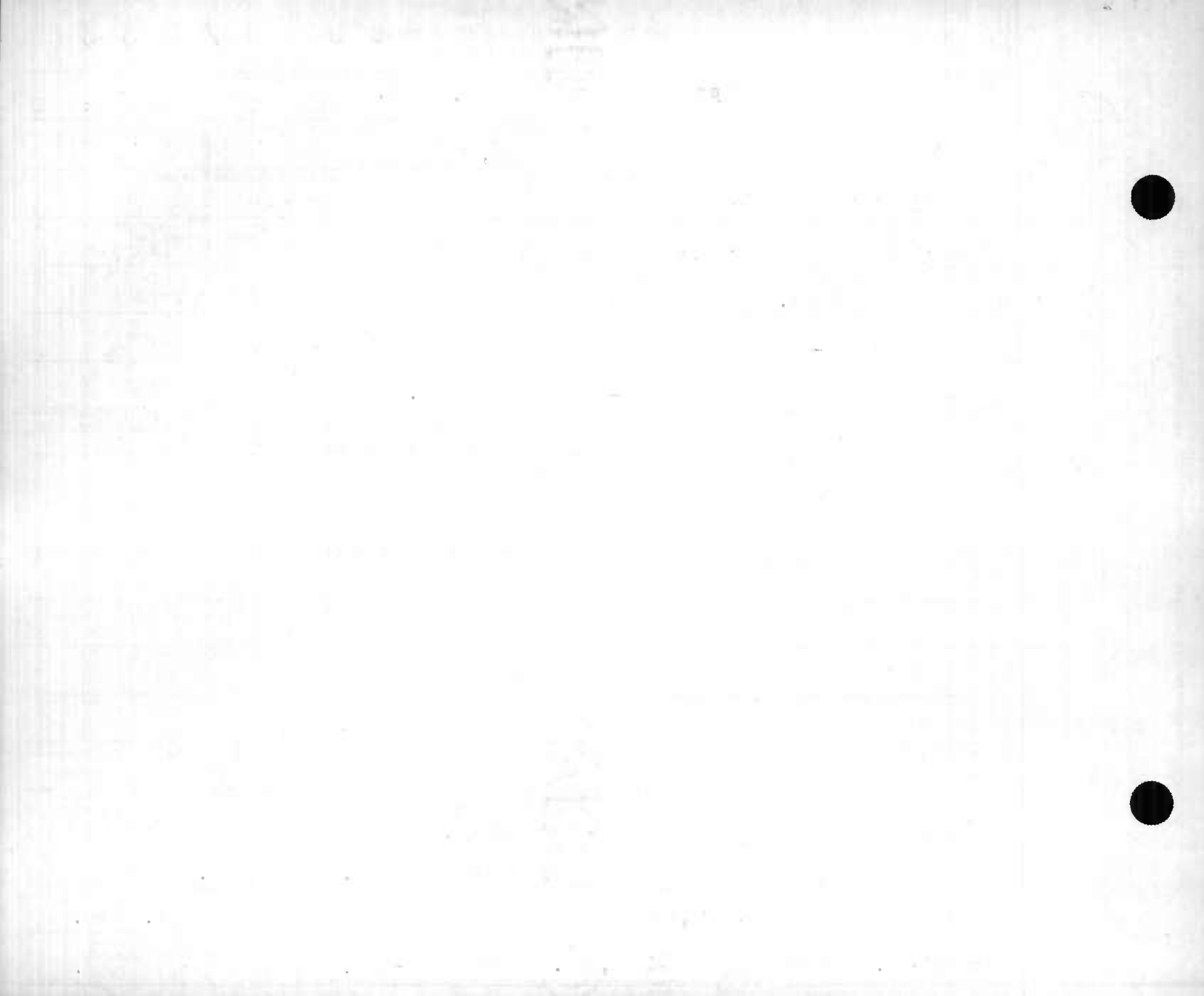
Wetland - Heller Bay (110) March 11, 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 0 0 7 8 3 3					
1. FOR STATE REGISTRAR					2a. DATE OF DEATH					MONTH DAY YEAR		2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST					MARCH 10 1980		6:51 P.			
3. SEX					4. RACE					5. DATE OF BIRTH					
Male					White					March 29, 1911					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?					8. AGE (IN YEARS LAST BIRTHDAY)					
Virginia					USA					68 YRS					
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
Rockville					Shady Grove Adventist Hospital					Presser					
13a. STATE					13b. COUNTY					13c. CITY OR TOWN					
Maryland					Mont.					Gaithersburg					
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					16. BALTIMORE CITY OR COUNTY OF DEATH					
FIRST MIDDLE LAST					FIRST MIDDLE LAST					Montgomery MD.					
John - Griffin					Pearl - Grady										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS					
no					213-14-2092					Rachael C. Griffin Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>										1 hr.					
410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u>															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
				P.M. 19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 4</u> 19 <u>73</u> to <u>FEB 29</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>FEB 29</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE										DEGREE				22c. DATE SIGNED	
<u>Frederick Moomau</u>										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/>				3/11/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS					
Frederick Moomau										Prince Philip Dr. Olney, Md. 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				March 14, 1980				Parklawn				Rockville Mont. Md.			
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE	
Francis H. Barber Laytonsville, Md. 20760										MAR 14 1980				<u>Robert McCreedy</u>	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JULIUS E. GUNTER			2a. DATE OF DEATH MONTH DAY YEAR 3 6 80		2b. HOUR 4:05 PM
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Feb 19 1914		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CHATTAM-NC	7b. CITIZEN OF WHAT COUNTRY? USA	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont. Co MD	
10. CITY OR TOWN OF DEATH Mont Co	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) JANITOR		12b. KIND OF BUSINESS OR INDUSTRY —
13a. STATE PG		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 7613-DEANSMEAD AVE - OX HILL MD
14. FATHER'S NAME FIRST MIDDLE LAST Lonnie A Gunter			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DAISY - THOMAS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 245-05-7820		17. INFORMANT ADDRESS SHirley DAVIS-7613-Deansmead Ave OX HILL MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 5839 DUE TO, OR AS A CONSEQUENCE OF: (b) Renal failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Uric Acid Nephropathy (Congenital absence of kidney) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Sepsis, Urinary Tract-infection, Vasculitis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/28 , 19 80 , to 3/6 , 19 80 , that (I) (we) lost saw the deceased alive on 3/6 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Alton R. Anderson		DEGREE MD		22c. DATE SIGNED 3/8/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alton R. ANDERSON MD		22e. ADDRESS 7600 Carroll Ave. Takoma Pk Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE March 13, 80		23c. NAME OF CEMETERY OR CREMATORY Sumner Cem	
23d. LOCATION CITY OR TOWN COUNTY STATE Pittbur 17C		24. FUNERAL DIRECTOR NAME ADDRESS Smiths Funeral Home 2116-18th St			
25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Anthony McBrady			

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BP

THE UNIVERSITY OF CHICAGO
LIBRARY

SEP 11 1954

CHICAGO, ILL.

TO THE CHICAGO BOTANICAL GARDEN

FROM A. E. DUNN, DEPT. OF BOTANY

UNIVERSITY OF CHICAGO

RECEIVED



SEP 11 1954

CHICAGO, ILL.

TO THE CHICAGO BOTANICAL GARDEN

FROM A. E. DUNN, DEPT. OF BOTANY

UNIVERSITY OF CHICAGO

CHICAGO, ILL.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0007835			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 3 6 80			
1. DECEASED NAME FIRST MIDDLE LAST JEANETTE ELIZABETH HALE				2b. HOUR 5 A.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 13 1910		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery, MD.	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BROOKE GROVE NURSG. HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Gaithersburg				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 871 Clopper Road,	
14. FATHER'S NAME FIRST MIDDLE LAST Robert F. Woods				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Doolittle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. none		17. INFORMANT (daughter) 18800 Stoneyhurst St. Phyllis Willey-Olney, Md.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Widespread Metastatic disease 1570 DUE TO, OR AS A CONSEQUENCE OF (b) (liver, lung, bone) Months Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of the head of pancreas Months							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (the hospital) attended the deceased from 1-25-80 to 2-13-80, that (1) (we) last saw the deceased alive on 2-15-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death.							
22b. SIGNATURE John R. Minarik, MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Minarik, MD				22e. ADDRESS Montgomery General Hosp., Olney, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-9-80		23c. NAME OF CEMETERY OR CREMATORY George Washington		23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi Pr. Georges Md.	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.				25a. DATE BY REGISTRAR 11 1980 25b. REG. NO. 111980			

COMMON FIBER



1950

1951

1952

1953



FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

078336

1. DECEASED NAME (TYPE OR PRINT) MARTHA HAMBURGER			2a. DATE OF DEATH MONTH DAY YEAR 3-24-80			2b. HOUR 2:40 AM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JULY 17, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 51		7. IF UNDER 1 YEAR MONTHS DAYS YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) WASHINGTON, DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY DRUG STORE			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MARYLAND			13c. COUNTY PR. GEORGES		13d. CITY OR TOWN HYATTSVILLE		13e. STREET ADDRESS 8102 15th AVENUE, APT. 202		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN COLLINS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE KAHANSKY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 577-38-8725		17. INFORMANT ADDRESS MRS. LILLIAN N. GAMPEL 11316 NEWPORT MILL ST. SP. MD. RD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) lung cancer, metastatic DUE TO, OR AS A CONSEQUENCE OF (c) chronic cystitis post-surgery APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: None									
19a. DATE OF OPERATION 3/24/80			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pneumonia			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from 3/10/80 to 3/24/80 , that (1) (we) last saw the deceased alive on 3/24/80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.									
22b. SIGNATURE H.L. Marter			DEGREE			22c. DATE SIGNED 13/25/1980			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H.L. MARTER			22e. ADDRESS 831 W. ...						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3/26/1980		23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY		23d. LOCATION CITY OR TOWN COUNTY ADELPHI PR. GEORGES, MD.		
24. FUNERAL DIRECTOR NAME ADDRESS DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.					25a. DATE REC'D. BY REGISTRAR MAR 28 1980				
					25b. REGISTRAR'S SIGNATURE Antony McCreedy				

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 0 0 7 8 3 7				
1. FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) Ruth H. Hammond			2a. DATE OF DEATH March 4 1980		2b. HOUR 3:25 P.M.		
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH Aug. 7, 1891		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS		7 UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.			
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Chevy Chase Nursing Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Director		12b. KIND OF BUSINESS OR INDUSTRY Oberlin College		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE D.C.		13c CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 409 N St., S.W.			
14 FATHER'S NAME FIRST MIDDLE LAST Robert R. Hammond		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine White		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 572-28-9046 A		17 INFORMANT Peter P. Hammond	
				17 ADDRESS Same as 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac standstill</u> <u>410-</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarct</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>15 min.</u> <u>24 hours</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (the hospital) attended the deceased from <u>12 7 5</u> , 19 <u>80</u> , to <u>3/4</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>1 March</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Milton Gusack, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED March 4 1980			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Milton Gusack M. D.				22e ADDRESS 1100 22nd St. N. W. Wash., D. C. 20037					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b DATE Mar. 5 1980		23c NAME OF CEMETERY OR CREMATORY Uniformed Services University of the Health Sciences		23d LOCATION COUNTY STATE Bethesda, Md.			
24 FUNERAL DIRECTOR NAME Capitol Funeral Service				ADDRESS Fairfax, Va.		25a DATE REC'D. BY REGISTRAR MAR 10 1980		25b REGISTRAR'S SIGNATURE <u>History McCreedy</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR	
CHARLES BURTON		HANCOCK						MAR 22 1980										2210 P ^M	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH JULY 11 1912		6. AGE (IN YEARS LAST BIRTHDAY) 67		7. UNDER 1 YEAR MONTHS		7. UNDER 24 HRS DAYS		HOURS		MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN) GEORGIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY													
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (TYPE OF FACILITY, ONE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY N/A													
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE FLORIDA		13b. COUNTY PENNSYLVANIA		13c. CITY OR TOWN SEMINOLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8700 KENWOOD ROAD									
14. FATHER'S NAME FIRST CHARLES MIDDLE MUNSON LAST HANCOCK		15. MOTHER'S MAIDEN NAME FIRST ANNA MIDDLE {NMN} LAST HORNE																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II		16c. SOCIAL SECURITY NO. 224-30-9684		17. INFORMANT J. SEARS, 9638 CANTRELL TER, S.S. MD													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SEPSIS 185- DUE TO, OR AS A CONSEQUENCE OF (b) WIDESPREAD METASTATIC DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) PROSTATIC CARCINOMA																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		No																	
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that (I) (this hospital) attended the deceased from 13 FEB 19 80 to 22 MAR 19 80, that (we) last saw the deceased alive on 22 MAR 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE Robert W. Timmons		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 23 MAR 80													
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Timmons, MD		22e. ADDRESS % NATIONAL NAVAL MED CTR																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/26/80		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery Brentwood PG Md.		23d. LOCATION CITY OR TOWN COUNTY STATE													
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.11800 N.H.Ave. S.S.Md.		ADDRESS MAR 27 1980		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Kristy McCready													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

Cleared Medical Certification M.E.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 0007839									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Thomas J Haropoulos								3.28.80		9:34 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
Male		Caucasian		Nov. 19 1893		86					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Greece		U.S.A.				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda		Suburban Hospital				Retired Furrier			Furrier		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md.		Montgomery		Rockville				13207 Twinbrook Pkwy.			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
John Haropoulos				Ourania Fijos							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
no				319-20-9220		Irene Haropoulos (same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>GENERALIZED METASTATIC</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
185- } DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA OF PROSTATE</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE 1978</u> to <u>MAR 28 1980</u> , that (I) (we) last saw the deceased alive on <u>MAR 13 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>R.C. Daddario</u>				DEGREE <u>M.D.</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3/29/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ROBERT E. DADDARIO</u>				22e. ADDRESS <u>5413 CEDAR LANE BETHESDA</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		4-1-80		Gate of Heaven Cem.,		Silver Spring Montg. Md.					
24. FUNERAL DIRECTOR NAME <u>ROBERT A. PUMPHREY FUNERAL HOMES P/A</u>				ADDRESS <u>ROCKVILLE MD.</u>		25a. DATE REC'D. BY REGISTRAR <u>APR 7 1980</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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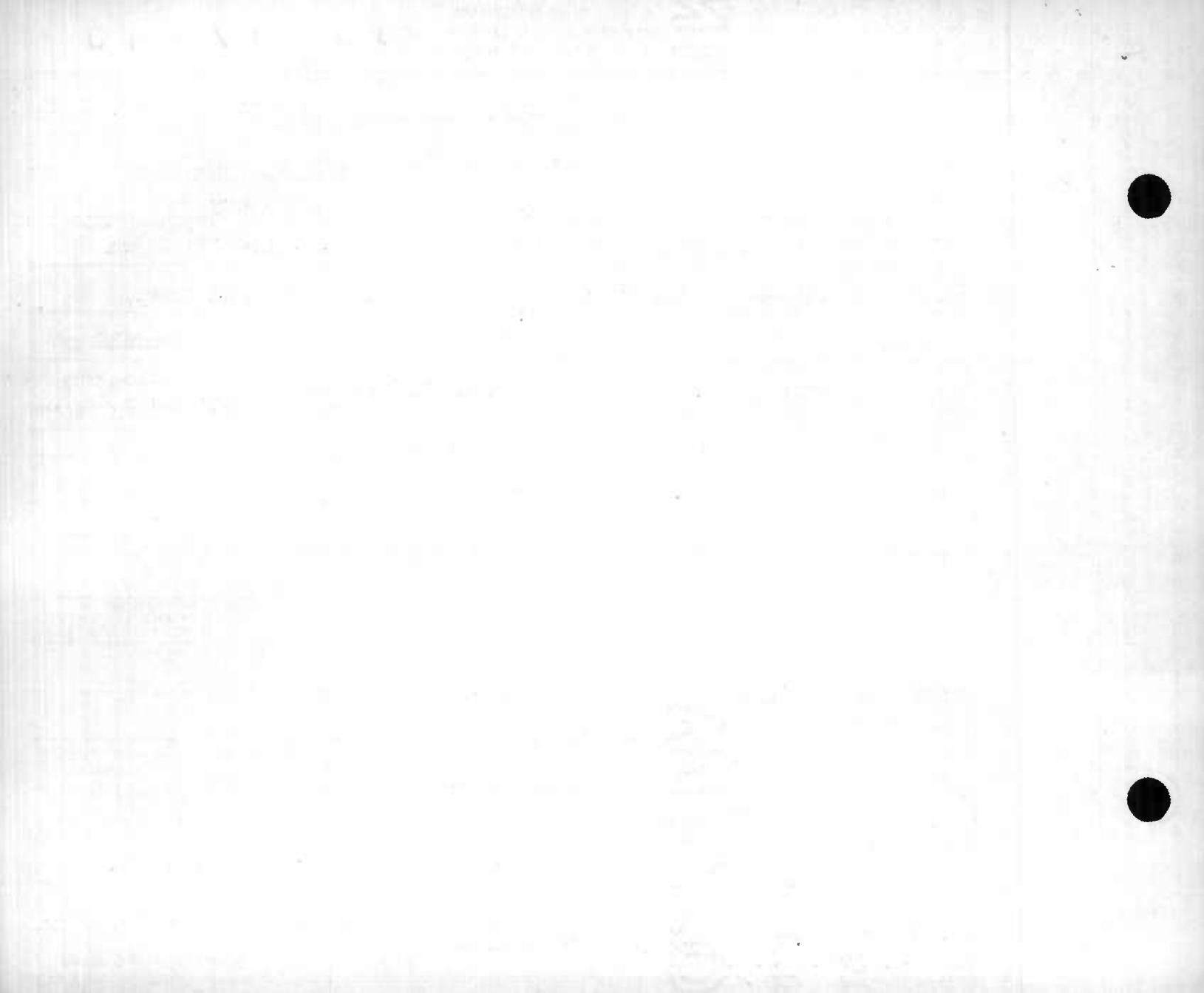
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 0 0 7 8 4 0							
1. DECEASED NAME (TYPE OR PRINT) Elizabeth D. Harper				2a. DATE OF DEATH MONTH DAY YEAR March 13, 1980				2b. HOUR P. 1:20 AM.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 5 1908		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairland Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland				13c. CITY OR TOWN Sil. Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2101 Fairland Road,	
14. FATHER'S NAME FIRST MIDDLE LAST James Nicol				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Janet Donaldson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO 276-14-1301		17. INFORMANT (son) Robert G. Harper-		ADDRESS 5701 Gloster Rd. Bethesda, Md.			
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Lung Disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 1 month 3 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Stroke</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7/78</u> , 19 <u>80</u> , to <u>3/13</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>2/12</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Richard Cioffi</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/14/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Cioffi, MD				22e. ADDRESS 10620 Georgia Avenue, S.S. Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3-14-1980		23c. NAME OF CEMETERY OR CREMATORY Metropolitan		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Fairfax Va.			
24. FUNERAL DIRECTOR Walter B. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.				25a. DATE REC'D. BY REGISTRAR MAR 17 1980		25b. REGISTRAR'S SIGNATURE <u>Robert McCreedy</u>			



Dr. John G. Ball notified and approved.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 0 0 7 8 4 1							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALBERT E HARRIS				2a. DATE OF DEATH MONTH DAY YEAR March 11 1980		2b. HOUR 5:45 P			
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Sept 27, 1906		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minn.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4003 Maryland Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Transmission man		12b. KIND OF BUSINESS OR INDUSTRY A. T. & T.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4003 Maryland Avenue	
14 FATHER'S NAME FIRST MIDDLE LAST Albert E. Harris, Sr.				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maud May					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 577-07-6682		17 INFORMANT Alice A. Harris		ADDRESS 4003 Maryland Avenue Bethesda, Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4140 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3-76 11-18-75									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that we <u>James F. Mackin</u> attended the deceased from <u>2-3</u> 19 <u>76</u> , to <u>3-11</u> 19 <u>80</u> , that <u>we</u> (we) last saw the deceased alive on <u>19 FEB</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE <u>James F. Mackin M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/12/1980			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James F. Mackin, M.D.				22e. ADDRESS 5401 Western Ave. NW, Wash., D.C.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Mar. 13, 1980		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Prince Georges, Md.			
24 FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., N. W., Washington, D. C.				25. DATE REC'D. BY REGISTRAR MAR 17 1980		26. REGISTRAR'S SIGNATURE <u>Robert M. Brady</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 07842	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Walter Richard Harvey Sr.							2a. DATE OF DEATH MONTH DAY YEAR 3-14-'80		2b. HOUR 2:25 A.M.		
3. SEX Male.		4. RACE White.		5. DATE OF BIRTH MONTH DAY YEAR July 13, 1906		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 73		7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.		7b. CITIZEN OF WHAT COUNTRY? C. U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery. MD					
10. CITY OR TOWN OF DEATH Takoma Park,		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) /Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Advertising Mgr.		12b. KIND OF BUSINESS OR			
13a. STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Takoma Park.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7213 Garland Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Walter B. Harvey.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST / Eleanor G.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 578-05-1426		17. INFORMANT Audrey H. Harvey		ADDRESS 13 e.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE 600 - Cardiac arrest with anticardiac thrombosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction, coronary tract infarction DUE TO, OR AS A CONSEQUENCE OF (c) hypertensive and diabetic cardiovascular disease										day. years.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Status post cerebrovascular accident											
19a. DATE OF OPERATION 3/13/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from 3/13/80 to 3/14/80 , that (I) (we) last saw the deceased alive on 3/13/80 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE Frederic C. Mummend						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/14/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) F.W. BRENNWALD						22e. ADDRESS 831 University Blvd E Silver Spring.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 17, 1980		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Rd. P. Geo. Md.					
24. FUNERAL DIRECTOR Arthur M. Walters		25. ADDRESS 254 Carroll St N.W. Washington D.C. 20032		26. RECEIVED BY REGISTRAR MAR 19 1980		27. REGISTRAR'S SIGNATURE Arthur M. Walters					

Continued on p. 100, 101.

No. 273-02-1438 Arthur H. Harvey 11 a.

Walter H. Harvey.
1213 Garland Ave.
Takoma Park, D. C. 20901
7313 Garland Ave.

Washington, D. C. 20540
Takoma Park, D. C. 20901
7313 Garland Ave.

July 12, 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO.			
1- REGISTRAR Edna I. Hawkins				STATE OF MARYLAND				0 07843			
1 DECEASED NAME (TYPE OR PRINT) Edna I Hawkins				2a. DATE OF DEATH MONTH DAY YEAR 3-23-80				2b. HOUR 6 10 AM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Sept. 13, 1896		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.		7b. CITIZEN OF WHAT COUNTRY? USA	
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6300 Windermere Circle			
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Pokorski				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Jaskowiak				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 165-01-8795 D				17 INFORMANT ADDRESS Lewis J. Lafera Same as Item # 13				18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Irreversible Congestive heart failure			
4292				DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic CardioVascular disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 weeks			
DUE TO, OR AS A CONSEQUENCE OF (c) 10 years				PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from February 29, 1980 , to March 23, 1980 , that (1) (we) last saw the deceased alive on March 23, 1980 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.				22b. SIGNATURE James E. Wilson Jr. M.D. DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/23/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James E. Wilson Jr., M.D.				22e. ADDRESS 11125 Rockville Pike, Rockville, Md. 20852							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/27/80		23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Newark, N.J.					
24 FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME ADDRESS 5130 Wisc. Ave. N.W. Wash., D.C.				25a. DATE REC'D BY REGISTRAR MAR 27 1980		25b. REGISTRAR'S SIGNATURE Robert McCreary					

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

07844

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Kermit Roosevelt Hawkins			2a. DATE OF DEATH MONTH DAY YEAR March 9, 1980			2b. HOUR 8:25 P.M.							
3 SEX Male		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2- 26-1906		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer (Retired)		12b. KIND OF BUSINESS OR INDUSTRY None					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Montg.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 19810 Goshen Road,				
14 FATHER'S NAME FIRST MIDDLE LAST Zachariah Hawkins			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susanna Stewart			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 219-01-8095-A		17 INFORMANT ADDRESS Mrs E. Virginia Hawkins (Wife)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Post Left Nephrectomy For Hypernephroma 1890 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (1)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 2-29 , 19 80 , to 3-9 , 19 80 , that (I) (we) lost saw the deceased alive on 3-9 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, and that (I) (we) saw the body after death.													
22b. SIGNATURE John P. Maylath, M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-10-80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN P. MAYLATH						22e. ADDRESS 30 W. F.D. M. DR. SPON. DR. ROCKVILLE, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-14-80		23c. NAME OF CEMETERY OR CREMATORY Brooke Grove Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Gaithersburg, Montg. Md.							
24 FUNERAL DIRECTOR NAME George R. Snowden						25. NAME OF REGISTRAR 1980							
26. ADDRESS 246 N. Washington Street Rockville, Md. 20850						27. REGISTRAR'S SIGNATURE [Signature]							

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

07845

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Alma Nichols Hebbert			2a. DATE OF DEATH MONTH 3 DAY 30 YEAR 80			2b. HOUR 330 P M					
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH Aug. DAY 5 YEAR 1891		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 		7. IF UNDER 24 HRS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH S.S.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colonial Villa Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 13612 Fairridge Drive			
14. FATHER'S NAME FIRST Charles E. MIDDLE Nichols LAST 						15. MOTHER'S MAIDEN NAME FIRST Martha MIDDLE Cain LAST 					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None				16b. SOCIAL SECURITY NO. 066 09 0870		17. INFORMANT Same as above D. R. Scott Hebbert (Son)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrhythmia 4409 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (this hospital) attended the deceased from Aug 1979 to MAR 30 , 19 80 , that (I) (we) lost the deceased alive on MAR 28 , 19 80 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.											
22a. SIGNATURE JOEL GOOZH FOR MARION CHUNG MD						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/30/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOEL GOOZH						22e. ADDRESS 4701 RANDOLPH RD Rockville MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 4/1/80		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery Brentwood PG Md.		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi						ADDRESS F.H. 11800 N.H. Ave. S.S. Md.		25. DATE REC'D. BY REGISTRAR APR 7 1980		25b. REGISTRAR'S SIGNATURE Dorothy McBratney	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

100-100000

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED



RECEIVED



NOTICE

100-100000

APR 1990

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 0 0 7 8 4 6	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) BERNARD HELFER				2a. DATE OF DEATH MONTH DAY YEAR March 9 1980				2b. HOUR 6:40 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9 25 04		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT		12b. KIND OF BUSINESS OR INDUSTRY APPLIANCE			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13. STREET ADDRESS 11477 OLD COLUMBIA PIKE			
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH HELFER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE KARMITZ							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO 578-05-9221A		17. INFORMANT ADDRESS EDYTHE HELFER, same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 492- DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Congestive heart failure											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from 2/7 1980 to 3/9 1980 , that (we) last saw the deceased alive on 3/9 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.											
22b. SIGNATURE Norman H. Rubenstein				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/10/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NORMAN H. RUBENSTEIN				22e. ADDRESS 11161 N.H. Ave. Silver Spring, Md. 20904							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/11/1980		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN		23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH, VIRGINIA					
24. FUNERAL DIRECTOR DANIEL M. STEIN HEBREW MEMORIAL FUNERAL HOME						25a. DATE REC'D. BY REGISTRAR MAR 13 1980		25b. REGISTRAR'S SIGNATURE Patrick McCreedy			
232 CARROLL STREET, N. W., WASHINGTON, D. C.											



THE NATIONAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535
JAN 10 1964
MEMORANDUM FOR THE DIRECTOR
SUBJECT: [Illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				07847			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNE LEE HELMERS				2a. DATE OF DEATH MONTH DAY YEAR 3 27 80			
3. SEX Female		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR OCT. 16. 1891		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM WAGER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA COOK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-72-6489		17. INFORMANT ADDRESS CAROLYN AHRENS (SAME AS #13c)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO Respiratory Arrest</u> 486- DUE TO, OR AS A CONSEQUENCE OF (b) <u>probable pulmonary Embolism</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bed rest with Pneumonia</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH One hour one hour 2 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>senile dementia, blindness</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/25/80, 19, to 3/27/80, 19, that (I) (we) last saw the deceased alive on 3/27/80, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Mary Ellen Coulter M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/27/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARY ELLAN COULTER				22e. ADDRESS Holy Cross Hospital 1300 Forest Glen Rd Silver Spring Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 31, 1980		23c. NAME OF CEMETERY OR CREMATORY First Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore P. H. Md.	
24. FUNERAL DIRECTOR NAME Inkoma Funeral Home, J.G. Natus				ADDRESS 234 Carroll St. NW		DATE REC'D. BY REGISTRAR APR 2 1980	
				25b. REGISTRAR'S SIGNATURE History McCreedy			

MEDICAL CERTIFICATION

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1- STATE REGISTRAR										707348	
1. DECEASED NAME (TYPE OR PRINT) FLOYD ALFONSO HELMS							2a. DATE KNOWN OF DEATH ESTIMATED 3/3 19 80		2b. HOUR 8:00 A.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 8, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD 3/3 19 80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) No. Carolina			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8111 Roanoke Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Printer		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8111 Roanoke Avenue		
14. FATHER'S NAME FIRST MIDDLE LAST John Daniels Helms						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Alice Snyder					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II 577-07-9592		17. INFORMANT Mrs. Edna O. Helms			ADDRESS (Same as # 13 above)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u> 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John S. Rogers</i>				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 3/3/80			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/6/1980		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Colmar Manor, P.G., Md.			
24. FUNERAL DIRECTOR NAME Arthur Walter						25a. DATE REC'D. BY REGISTRAR MAR 6 1980		25b. REGISTRAR'S SIGNATURE <i>Patricia McCreedy</i>			
24. FUNERAL DIRECTOR NAME Takoma Fun'l Home N.W., Wash. D.C.											

1. DECEASED NAME (TYPE OR PRINT) MARY		3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 3 1927		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery		10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk (R)		12b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.	
13a. STATE Maryland		13b. COUNTY Pr. George		13c. CITY OR TOWN Hillcrest Hgts		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2020 Iverson Court		14. FATHER'S NAME FIRST MIDDLE LAST John A. Partlow		15. MOTHER'S MAIDEN NAME MIDDLE LAST Effie Bailey		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 223-32-9030		17. INFORMANT Veronika Hendrick		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure 1749 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last: (b) Metastatic Carcinoma (c) Adenocarcinoma of Breast 6 yrs 16 mos		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE																					
22a. I certify that (I) (the hospital) attended the deceased from May 19 1984 to 3/26 19 80 , that (I) (we) lost saw the deceased alive on 3/26 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) viewed the body after death.																									
22b. SIGNATURE G. Lennard Gold, M.D.												DEGREE MD				22c. DATE SIGNED 3/28/80									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Lennard Gold, M.D.												22e. ADDRESS 8630 Fenton St., Silver Spring, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/29/80		23c. NAME OF CEMETERY OR CREMATORY Thornrose						23d. LOCATION CITY OR TOWN COUNTY STATE Staunton, Virginia															
24. FUNERAL DIRECTOR NAME ADDRESS Cunningham Funeral Home, Inc. Alex. Va.												25. DATE REC'D. BY REGISTRAR APR 8 1980				25b. REGISTRAR'S SIGNATURE Pinky McBrady									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

BP

DHMH - 16 25M

(VR A 15 (4) 1/7/74)

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Barbara BOSS Heron			2a. DATE OF DEATH MONTH DAY YEAR March 28, 1980			2b. HOUR 10:16 ^{AM}			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 2 - 24 - 1907		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH CHEVY CHASE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3528 HAMLET PLACE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD.		13b. COUNTY MONTG.		13c. CITY OR TOWN CHEVY CHASE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3528 HAMLET PLACE	
14. FATHER'S NAME FIRST MIDDLE LAST HARRY K. BOSS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANTOINETTE EBERLY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 216-46-8603		17. INFORMANT ADDRESS ALEXANDER M. HERON SAME AS # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coma 2001 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Lymphosarcoma DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Acute 3 Months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION 1/21/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholecystectomy				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Jan. 5, 1978, to Mar. 28, 1980, that (I) (we) lost saw the deceased alive on Mar. 25, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Frank J. Fedor				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED Mar 28, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank J. Fedor				22e. ADDRESS 20016 4201 Cathedral Ave. Washington DC					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-31-80		23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.			
24. FUNERAL HOME NAME JOSEPH CAWLER'S SONS, INC. 5139 WISC. AVE., N. W. WASH., D. C. 20016				25a. FILED BY REC'D. BY REGISTRAR APR 2 1980		25b. SIGNATURE [Signature]			

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) ANICE ELLA HERZIG			2a DATE OF DEATH MONTH DAY YEAR 03-25-80			2b HOUR 10³⁰ PM			
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR FEB 11-1913		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BETH. RETIREMENT & NURSING CTR		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSE		12b KIND OF BUSINESS OR INDUSTRY NURSING			
13a STATE MARYLAND		13b COUNTY MONT.		13c CITY OR TOWN ROCKVILLE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 20852 10201 GROSVENOR PLACE	
14 FATHER'S NAME FIRST MIDDLE LAST ISADORE HERZIG				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TESSIE SIEGLER					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO. 456-64-2088		17 INFORMANT ADDRESS EDWIN CHARNEY, HILLSDALE N.J.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3319 Chronic Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral atrophy 21 years DUE TO, OR AS A CONSEQUENCE OF (c) Alzheimer's disease 21 years PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS OR CONDITION GIVEN IN PART 1: No.									
19a DATE OF OPERATION W			19b CONDITION FOR WHICH OPERATION WAS PERFORMED No.			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from Jan 25 19 80 to March 25 19 80 , that (I) (we) last saw the deceased alive on March 25 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Irving Brotman			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 3-26-80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) IRVING BROTMAN			22e ADDRESS 1444 RT. AVE N.W.						
23a BURIAL, CREMATION, REMOVAL (DECEASED) CREMATION			23b DATE 3/26/80		23c NAME OF CEMETERY OR CREMATORY CEDAR HILL		23d LOCATION CITY OR TOWN COUNTY STATE SCITLAND P.G. Co. MD.		
24 FUNERAL DIRECTOR NAME W.W. CHAMBERS CO.			ADDRESS SILVER SPRING MARYLAND			25a DATE REC'D BY REGISTRAR MAR 31 1980		25b REGISTRAR'S SIGNATURE [Signature]	

1000

03-22-80 10 30

ALICE LARA HERSIG

FEMALE CAUCASIAN FEB 11-1913

New Jersey USA

German Born Protestant

Married Nov. 1930

2 children

Yes Will

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH-16 25M
(VRA 15, 4) 1/79

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.		0 0 7 8 5 2					
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR	
Julia C. Hicks				3 29 1980				7 p M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
female		white		MONTH DAY YEAR 12 25 1903		76 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Washington, D.C.		USA				Montgomery County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Sprg		Holy Cross Hosp Silver Spr Md				Homsewife		Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS			
Maryland				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2301 Glen Allan			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
Ulyess Kirkwood Owens				Un/k					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO		17. INFORMANT			
No				None		12704 55 Commons Way Robert D. Hicks Potomac, Md. 20854			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u>Acute Myocardial Infarction Thromb.</u> (c) <u>Arteriosclerotic Heart Disease yrs</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Cerebral Vascular Accident, Diabetes Mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 19 79</u> to <u>3/29 80</u> , that (I) (we) last saw the deceased alive on <u>3/25 80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>R.T. Bena ck MD</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3/29/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
R.T. Bena ck MD		4115 Colne Dr. Wheaton, Md							
23a. BURIAL, CREMATION, REMOVAL SPECIFY		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		Apr. 4, 1980		St. Johns Cemetery		Glen Forest Montg Md.			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
W.W. Chambers		8655 Georgia Ave, Sil.Spgs.				APR 7 1980		<u>W.W. Chambers</u>	

DHMH-16 25M
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White

White

Montgomery County

Silver Spur Rd

Half Cross Loop

Silver Spur

2001 Glen Allen

Section 1

1/2

Section 1

1/2 Section 1

1/2 - 2nd Subd.

1/2 - 2nd Subd.

Map of 1/2 Section 1

APR 5 1980

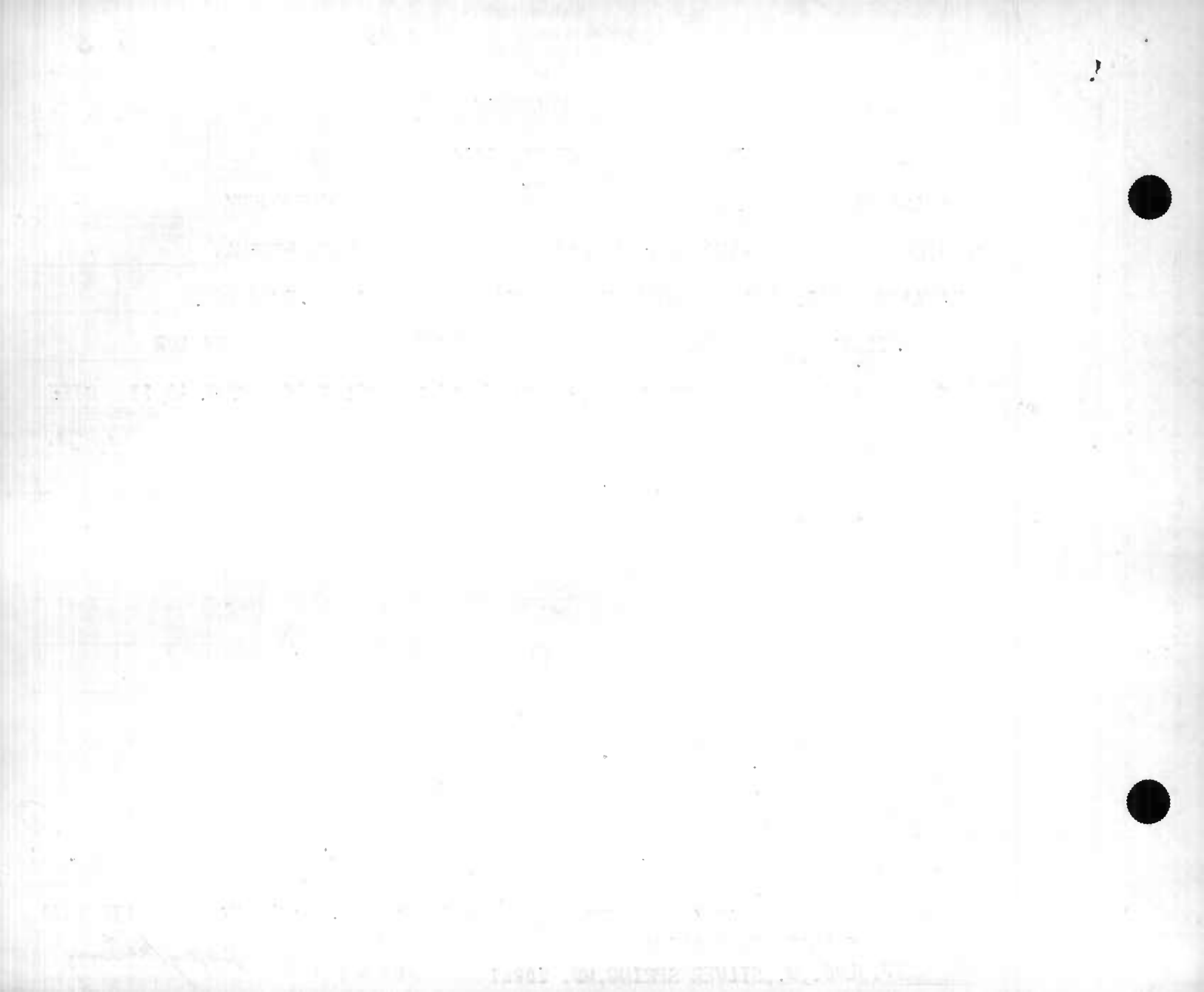
U.S. Department of the Interior

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 0007853							
1. DECEASED NAME (TYPE OR PRINT) ARTHUR MASON HOLBROOK, SR.		2a. DATE OF DEATH MONTH 3 DAY 9 YEAR 80		2b. HOUR 2 P. M.					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH OCT DAY 22 YEAR 1916		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WHEATON MANOR CARE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) D.C. FIREMAN		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. CITY OR TOWN PRI. GEO		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 14 Y RIDGE ROAD			
14. FATHER'S NAME FIRST PHILLIP MIDDLE LAST HOLBROOK					15. MOTHER'S MAIDEN NAME FIRST ESSIE MIDDLE LAST TAYLOR				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-12-0946		17. INFORMANT ADDRESS ELLEN LOUISE HOLBROOK SAME AS 13 WIFE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 486- APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs 2 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from N/A 19 to 19 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Alan I. Kermaier		DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9 Mar 80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN I. KERMAIER, MD		22e. ADDRESS 9501 GEORGIA AVE. S.S. MD 20902							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 3/10/80		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY		23d. LOCATION CITY OR TOWN ALEXANDRIA		COUNTY VIRGINIA	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD, 20901				25a. DATE REC'D. BY REGISTRAR MAR 10 1980		25b. REGISTRAR'S SIGNATURE Anthony McCreedy			



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

07854

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) James M. Hollis			2a. DATE OF DEATH MONTH 3 DAY 11 YEAR 80 2b. HOUR 2:55 PM		
3 SEX male	4 RACE white	5. DATE OF BIRTH MONTH Nov. DAY 15 YEAR 1920	6 AGE (IN YEARS LAST BIRTHDAY) 59 YRS		7. IF UNDER 1 YEAR MONTHS DAYS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10 CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) D. C. Gov't.		12b KIND OF BUSINESS OR INDUSTRY
13a STATE Maryland			13b COUNTY Montgomery	13c CITY OR TOWN Wheaton	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST James MIDDLE M. LAST Hollis			15 MOTHER'S MAIDEN NAME FIRST Alberta MIDDLE S. LAST Stephenson		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. WWII 579-18-5270		17 INFORMANT wife ADDRESS same as 13c	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio pulmonary failure DUE TO, OR AS A CONSEQUENCE OF (b) myocardial M.I. DUE TO, OR AS A CONSEQUENCE OF (c) ASHD / CAD / chronic lung disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) chronic lung disease / alcoholic liver disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2-24 , 19 80 , to 3-11 , 19 80 , that (I) (we) last saw the deceased alive on 3-11 , 19 80 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (do) not view the body after death.					
22b. SIGNATURE Jeffrey Alan Smith MD		22c. DATE SIGNED 3-11-80		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeffrey Alan Smith MD	
22e. ADDRESS 1760 Condlow Ave Takoma Park, MD		22f. PHYSICIAN'S SIGNATURE Jeffrey Alan Smith			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 14, 1980		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
23d. LOCATION CITY OR TOWN Brentwood		23e. COUNTY Montgomery		23f. STATE Md.	
24 FUNERAL DIRECTOR NAME Francis J. Collins		24b. ADDRESS 500 University Blvd., W. Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR MAR 11 1980	
25b. REGISTRAR'S SIGNATURE Anthony McCreedy					

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

DATE: OCT. 17, 1920

TO: Mr. J. H. ...

FROM: Mr. J. H. ...

SUBJECT: ...

RE: ...

... 270-12-2370 ...

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 07855			
1. DECEASED NAME (TYPE OR PRINT) Stanley Benton Holloway												2a. DATE KNOWN OF DEATH XX MONTH 3 DAY 21 YEAR 1980			
3. SEX male		4. RACE white		5. DATE OF BIRTH 12/11/51		6. AGE (IN YEARS) 28		IF UNDER 1 YR. MONTHS XX DAYS XX		IF UNDER 24 HRS. HOURS XX MIN XX		2c. DATE PRONOUNCED DEAD 3 MONTH 21 DAY 19 YEAR 80		2d. HOUR 1:05A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10. CITY OR TOWN OF DEATH Gaithersburg				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Route 355 and Brink Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Contractor				12b. KIND OF BUSINESS OR INDUSTRY Building			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Clarksburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 13100 Prices Distillery Road							
14. FATHER'S NAME FIRST William MIDDLE Holloway LAST Beulah				15. MOTHER'S MAIDEN NAME FIRST Beulah MIDDLE Webster LAST Webster											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. Viet Nam 214-60-5243				17. INFORMANT ADDRESS Nancy L. Holloway, same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Cranio-cerebral injury												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) 8150															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? XX 3/21/80				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of auto/lost control/fixed object							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway				21f. LOCATION STREET Route 355 & Brink Rd. CITY OR TOWN Gaithersburg COUNTY MontCo. STATE MD							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE H.R. Swad				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 3/21/80			
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.				ADDRESS 111 Penn Street, Balto., MD 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3/24/80				23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery				23d. LOCATION CITY OR TOWN Silver Spring COUNTY Maryland STATE MD			
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A.								25a. DATE REC'D. BY REGISTRAR MAR 28 1980				25b. REGISTRAR'S SIGNATURE [Signature]			
300 West Montgomery Avenue, Rockville, MD															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 0 0 7 8 5 6									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Frances A.		Hooe						March 5 1980		10 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
FEMALE		WHITE		JULY 16 02		77 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.	
CALIF.		USA				Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda		Suburban Hospital		HOUSEWIFE							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Mont.		Rockville				820 Fordham Street			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Thomas		Allen		Alice		Howsome					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
NO		578 26 3528		BETTY H. HANNAN		SHAME AS # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 436- DUE TO, OR AS A CONSEQUENCE OF (b). RT. Hemispheric CVA DUE TO, OR AS A CONSEQUENCE OF (c). 4 DAYS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). none											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
none		N/A									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 3/5/80, 19 80, to 3/5, 19 80, that (I) (we) last saw the deceased alive on 3/5, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
						3/5/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
CARL I. MARGOLIS, M.D.		11404 OLD GEORGETOWN RD. ROCKVILLE									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		3-8-80		WARRENTON CEM.		WARRENTON VIRGINIA					
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
John F. DeLoe		WASH. D.C.		MAR 10 1980		Anthony McCreedy					
DEVOL FUNERAL HOME											

MAR 1 1983

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR			REG. NO. 07857							
1. DECEASED NAME (TYPE OR PRINT) FLORENCE J. HOOKER			2a. DATE OF DEATH MONTH DAY YEAR March 13, 1980			2b. HOUR 11:15p				
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 3 17 1913		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home			
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST (unknown)			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (unknown)			16. STREET ADDRESS 3271 S. Leisure World Blvd				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			16b. SOCIAL SECURITY NO 022-10-7027		17 INFORMANT (husband) ADDRESS Richard Hooker- (same as 13e)					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute cardiopulmonary arrest</u> 4151 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) <u>probable pulmonary embolism</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/12</u> , 19 <u>80</u> , to <u>3/13</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>3/13</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>[Signature]</i>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/13/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sheldon R. Marchel MD			22e. ADDRESS 1811 Prince Philip Dr Olney Md							
23a. BURIAL, CREMATION, REMOVAL (TYPE) Cremation			23b. DATE 3-16-80		23c. NAME OF CEMETERY OR CREMATORY Metropolitan		23d. LOCATION CITY OR TOWN COUNTY STATE Alex. Fairfax Va.			
24. FUNERAL HOME NAME ADDRESS Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.					25a. DATE REC'D. BY REGISTRAR MAR 24 1980		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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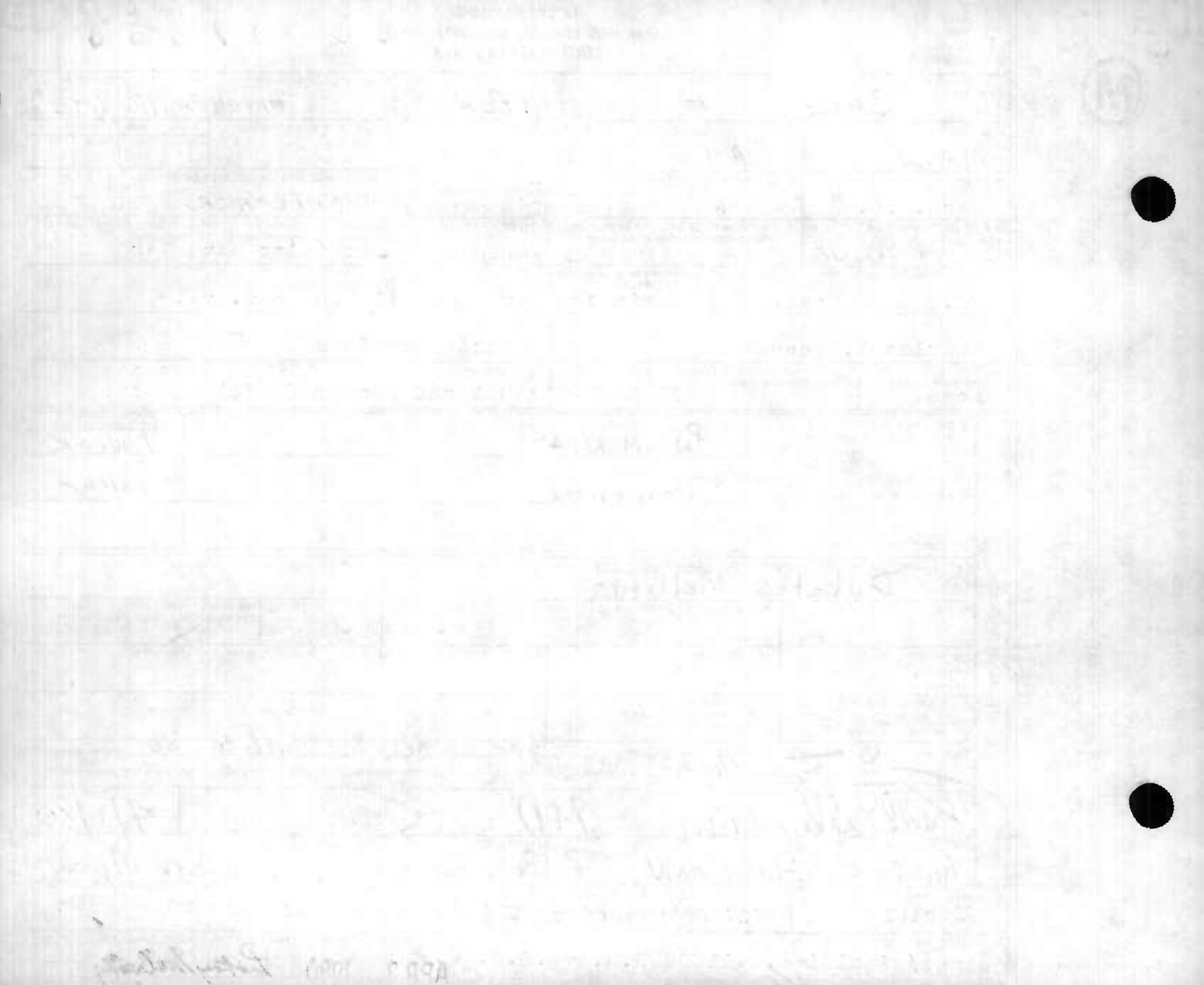
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO.		007858							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR		
CARL F HOOPER						MARCH 30, 1980			9:45 A M		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		CAU.		MONTH DAY YEAR 6/29/99		80		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Wash. D.C.		USA				MONTGOMERY County MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
SILVER SPRING		HOLY CROSS HOSPITAL				Machinist Navy		Yard			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.		Mont.		Kensington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		10920 Conn. Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Charles R. Hooper						Katie Harrison					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS		Same as			
None		577 18 3490		A Mildred Hooper (Wife)		Above					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA										1 week	
DUE TO, OR AS A CONSEQUENCE OF (b) Dementia										1 year	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Diabetes Mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (the hospital) attended the deceased from Jan 1, 1980, to March 30, 1980, that (1) (we) lost saw the deceased alive on March 29, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If deceased did not view the body after death.)											
22b. SIGNATURE		DEGREE				22c. DATE SIGNED					
Ralph E. Seligmann		MD				4/1/80					
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS									
RALPH E. SELIGMANN		8630 FENTON ST. SIL. SPR. MD 20910									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		23e. REGISTRAR'S SIGNATURE			
Burial		4/2/80		Cedar Hill Cemetery		Sutland		Md.			
24 FUNERAL DIRECTOR NAME		24b. ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Hines/Rinaldi		F.H. 11800 N.H. Ave. S.S. Md				APR 7 1980		R. Hines			



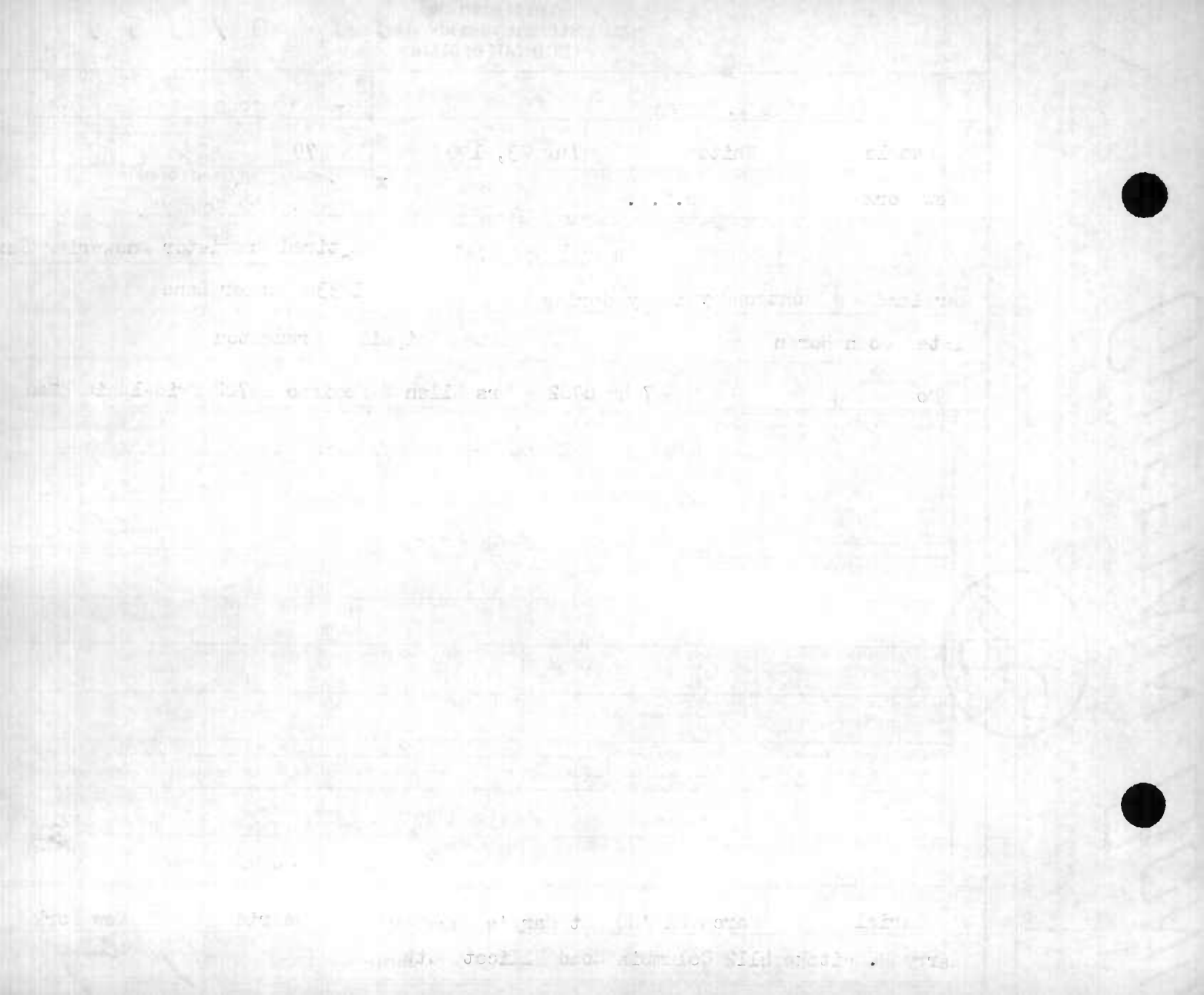
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Catherine B. Horan			2a. DATE OF DEATH MONTH DAY YEAR March 17 1980			2b. HOUR 2:10pM			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug 23, 1900		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Proprietor		12b. KIND OF BUSINESS OR INDUSTRY Answering Ser		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Sandy Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST late John Horan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST late Abigail Fraughton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 547 48 6762		17. INFORMANT ADDRESS Mrs Ellen F Femiano 14702 Tridslphia Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic pulmonary insufficiency 7373 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Kyphoscoliosis DUE TO, OR AS A CONSEQUENCE OF (c) Polio myelitis (age 12)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr 30 yr 62 yr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from 3/10 , 19 80 , to 3/17 , 19 80 , that (I) (we) lost saw the deceased alive on 3/17 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE And Bonifant			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/17/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bonifant			22e. ADDRESS 18111 Prince Philip Dr. Stacey, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE March 21 '80		23c. NAME OF CEMETERY OR CREMATORY St Mary's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Madrid New York		
24. FUNERAL DIRECTOR NAME ADDRESS Harry H. Witzke 4112 Columbia Road Ellicott Ct					25a. DATE REC'D. BY REGISTRAR MAR 21 1980		25b. REGISTRAR'S SIGNATURE Anthony McCready		

MEDICAL CERTIFICATION

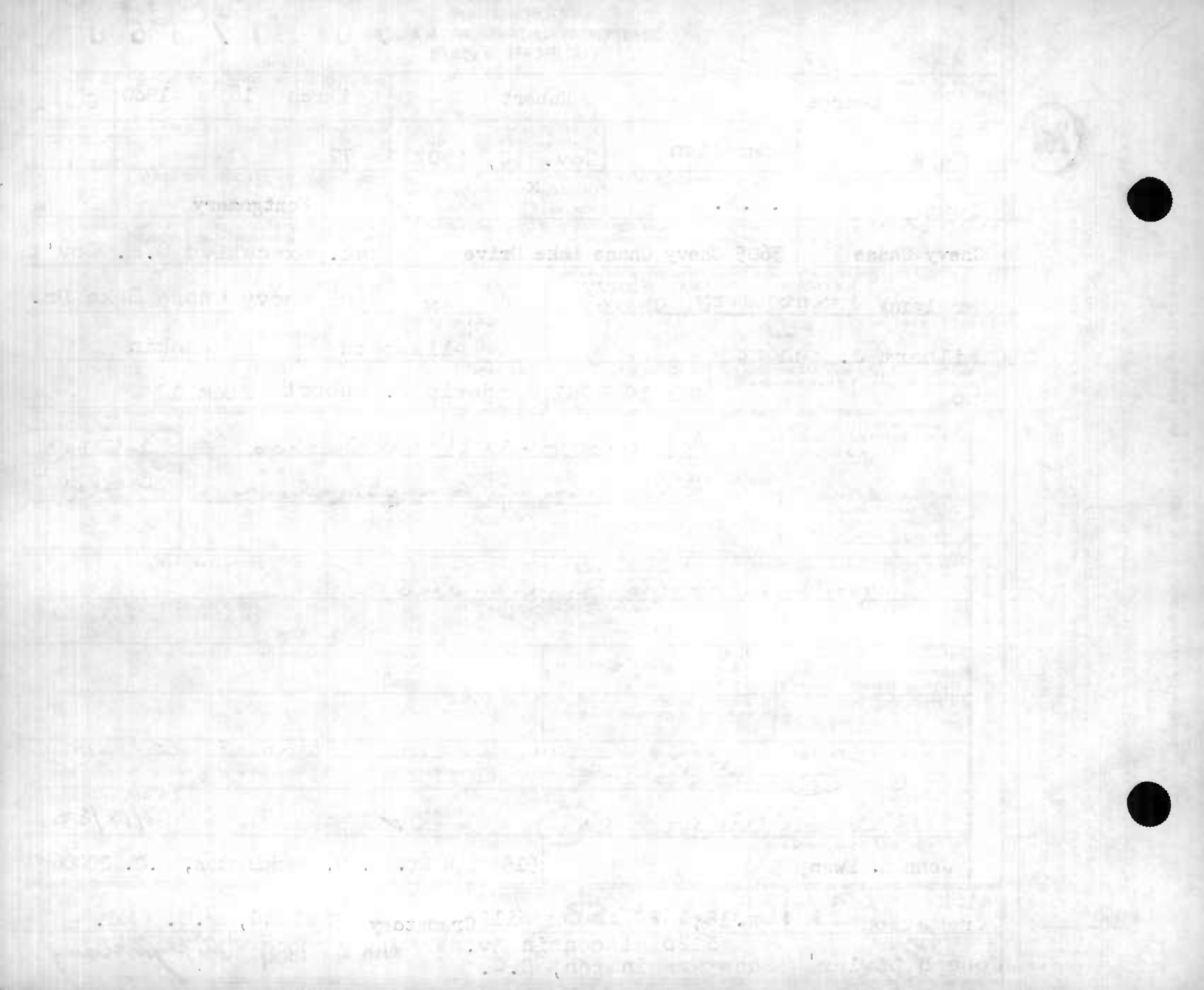


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO.				0 0 7 8 6 0				
1. DECEASED NAME (TYPE OR PRINT) George Holmes Hubert					2. DATE OF DEATH MONTH DAY YEAR March 18 1980					2b. HOUR 5:00 AM
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 16, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		7. UNDER 1 YEAR MONTHS DAYS		7. UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD				
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3605 Chevy Chase Lake Drive				12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Executive		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY Chevy Chase		14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		15. STREET ADDRESS 3605 Chevy Chase Lake Dr.		
14. FATHER'S NAME FIRST MIDDLE LAST Wilbert J. Hubert					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Rankin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 483 10 6041		17. INFORMANT ADDRESS Marjorie B. Hubert Item 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>4/1/80</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 Yr</u> <u>20 Yr</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Guillain Barre Syndrome</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1, 1980</u> to <u>Mar. 18, 1980</u> , that (I) (we) lost <u>saw the deceased alive on</u> <u>Mar. 6, 1980</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										
22b. SIGNATURE <u>John R. Ewan</u>				DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/18/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Ewan				22e. ADDRESS 916 19th St. N. W. Washington, D.C. 20006						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Mar. 18, 1980		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G. Md.				
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons		24b. ADDRESS 5136 Wisconsin Av. N.W.		25. DATE REG'D. BY REGISTRAR MAR 21 1980		25b. REGISTRAR'S SIGNATURE <u>Jeffrey McCreedy</u>				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSMIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 77 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

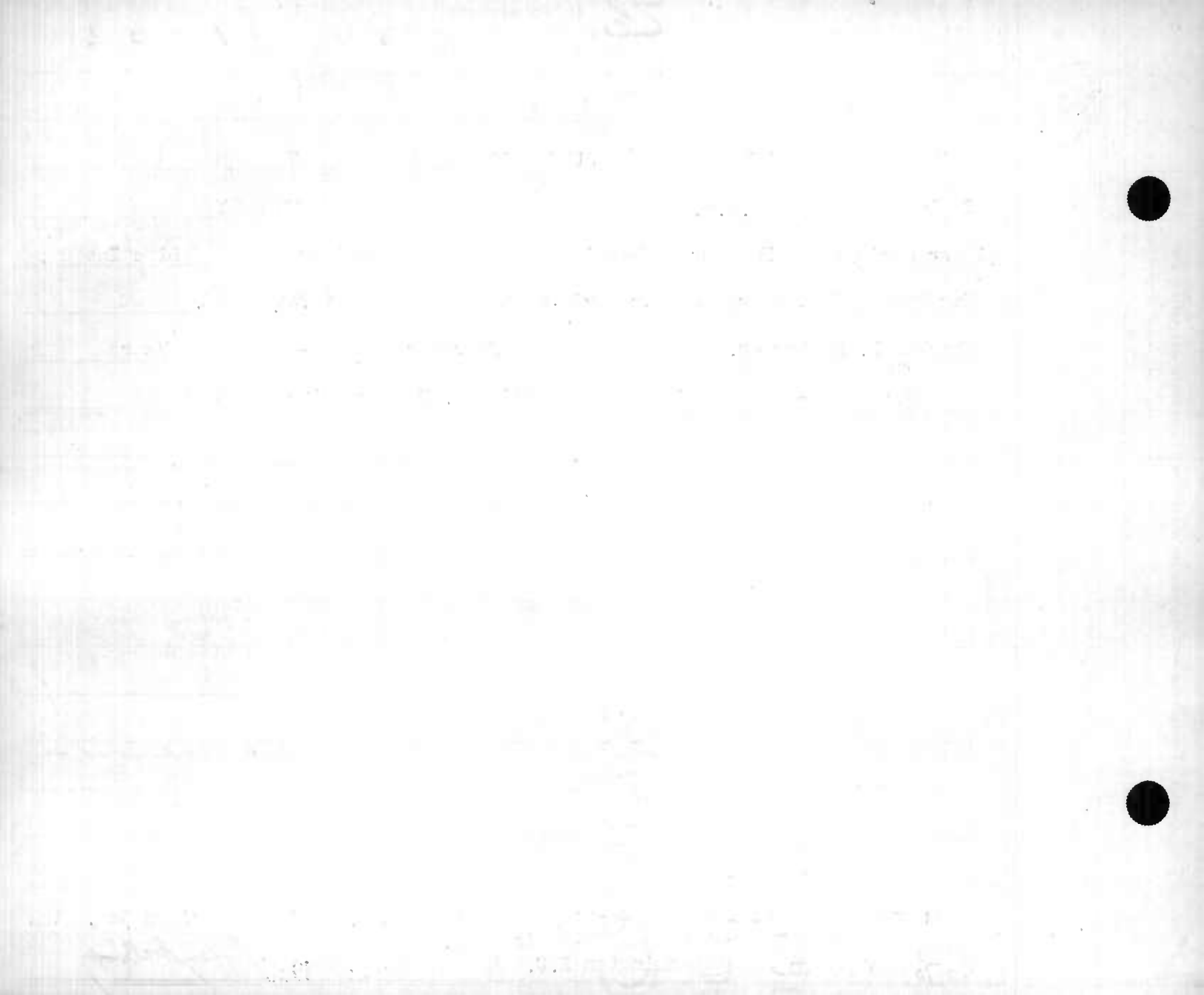
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												07861 REG. NO.			
1- FOR STATE REGISTRAR															
2- DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST James Chaplain Hughes												7a. DATE KNOWN OF DEATH MONTH DAY YEAR 3-30-80		7b. HOUR DAY MONTH YEAR 5:58 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9-7-12		6. AGE (IN YEARS) LAST BIRTHDAY 67 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3-30-80		7d. HOUR DAY MONTH YEAR 5:58 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Takoma Park				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician				12b. KIND OF BUSINESS OR INDUSTRY Construction			
13a. STATE Md		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Adelphi		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8215 18th Ave							
14. FATHER'S NAME FIRST MIDDLE LAST Thomas M. Hughes						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Beall									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II				16b. SOCIAL SECURITY NO. 045 01 7488				17. INFORMANT ADDRESS Louise E. Hughes Same as #13 (Wife)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> TITLE (SPECIFY) MEDICAL EXAMINER DATE SIGNED March 30, 1980															
ACTUAL SIGNATURE John S. Rogers				EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D. ADDRESS 1919 Seminary Rd. Silver Spring, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 4/2/80				23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.			
24. FUNERAL HOME NAME Gorsch's Sons Funeral Home, P.A. ADDRESS Hyattsville, Maryland								25a. DATE RECEIVED BY REGISTRAR APR 2 1980				25b. REGISTRAR'S SIGNATURE Robert H. Crumley			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 0 0 7 8 6 2							
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			
Charles H. Hunter			3/29/88			11 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			
MALE		WHITE		JUNE 18 1907		72 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Indiana		U.S.A.				MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Springs		Holy Cross Hospital		Auditer		Life Ins Co.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			
Maryland		Montgomery		Silver Springs		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS					
Charles H. Hunter Sr.		Florence Henry		546 Beacon Rd. #E					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No		577 03 4840		Edith O. Hunter/ Wife/ Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u>									
436- DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Septicemia, Chronic Obstructive Pulmonary Disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>November 10 1978</u> to <u>MARCH 29 1980</u> , that (I) (we) last saw the deceased alive on <u>MARCH 29 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
<u>Barry Hecht</u>		M.D.				MARCH 31, 1980			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
BARRY HECHT		10620 GEORGIA AVENUE SILVER SPRING, MD 20902							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
BURIAL		4-3-80		Washington National Cem.		SUITLAND PRINCE GEO. MD.			
24. FUNERAL DIRECTOR		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR		24d. REGISTRAR'S SIGNATURE			
DeVol Funeral Home		2222 Wisc Ave.		APR 7 1980		<u>Barry Hecht</u>			
NAME Robert A. DeVol		WASHINGTON D.C.							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMM-16 25M
(VRA 15, 4) 1/79

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 0 7 8 6 3

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE J. LAST HUSSEY			2a. DATE OF DEATH MONTH 3 DAY 10 YEAR 80			2b. HOUR 452 PM				
3 SEX Female		4 RACE C		5. DATE OF BIRTH MONTH 5 DAY 21 YEAR 01		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY		7b. CITIZEN OF WHAT COUNTRY? U.S.H.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME		
13a. STATE Md			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Collingswood N.H. 299 Hurley Ave	
14. FATHER'S NAME FIRST JOHN MIDDLE LAST DOTTER			15. MOTHER'S MAIDEN NAME FIRST AGATHA MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO 086-05-5047	
17. INFORMANT JOAN CHISOLM			ADDRESS 10121 WEATHERWOOD CT BETHESDA MD 20854			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary and cerebrovascular insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>atherosclerosis</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes YES YES	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>March 8, 1980</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										
22b. SIGNATURE Robert Millman			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/10/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Millman MD			22e. ADDRESS 1512 Deer Park Dr. Gaithersburg Md 20878							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3-14-80		23c. NAME OF CEMETERY OR CREMATORY LAKE WALKER CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE LAKE WALKER FLA			
24. FUNERAL DIRECTOR NAME METROPOLITAN FUNERAL SERV.			ADDRESS 5577 VINE ST. VA.			25a. DATE REC'D. BY REGISTRAR MAR 17 1980		25b. REGISTRAR'S SIGNATURE [Signature]		

BP

no
Tom
the
Gardner
U.S.H.
2nd Ave. 1st St.
1st Ave. 1st St.
1st Ave. 1st St.
1st Ave. 1st St.

3-11-50 San Juan Co. 2771122
3-11-50 San Juan Co. 2771122

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7. REG. NO. 0 0 7 8 6 4							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alma Jacobson					2a. DATE OF DEATH MONTH DAY YEAR 3-24-80			2b. HOUR 2:51 A.M.	
3. SEX Female		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 2 29 1892		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		8. UNDER 1 YEAR MONTHS DAYS 9. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Cherry Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BETHESDA RETIREMENT & NURSING CTR.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1220 Blair Mill Road, #1108	
14. FATHER'S NAME FIRST MIDDLE LAST Aaron Grollman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Fuld					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 226-14-4768A		17. INFORMANT ADDRESS Dr. Marshall H. Jacobson Washington, D. C.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Atherosclerotic & valvular Heart Disease DUE TO, OR AS A CONSEQUENCE OF: (c) Left Thoracic Fracture of Six ribs, Recurrent urinary infection, Gram									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Left Thoracic Fracture of Six ribs, Recurrent urinary infection, Gram									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from July 1978 to Present 19__, that (I) (we) lost the deceased alive on March 21 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE Charles B. Abrams				DEGREE Attending Physician				22c. DATE SIGNED 3/24/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES B. ABRAMS, M.D.				22e. ADDRESS 2141 K Street, N. W., Washington, D. C. Suite 702 20037					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/25/1980		23c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden			23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia		
24. FUNERAL DIRECTOR NAME Donald M. Stein				24b. ADDRESS 232 Carroll Street, N. W. Washington, D. C.			25. DATE REC'D. BY REGISTRAR (25) REGISTRAR'S SIGNATURE MAR 28 1980		

CHARLES E. ARNOLD, U.S.

1211 K Street, N.W., Washington, D.C.

1913

2/12/1913

King David Memorial Hospital, Baltimore, Md.

151 Carroll Street, N.W., Washington, D.C.

1913

Arnold

Brooklyn

St. Paul

1913

St. Paul

1913

St. Paul

St. Paul

St. Paul

WHITE BETHEM RETIREMENT & NURSING CT. Housville

U. S. A.

WHITE

1892

WHITE

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

07865

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Thomas NMN JACOBSEN			2a. DATE OF DEATH MONTH DAY YEAR 3 7 80			2b. HOUR 9:35 A M			
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR August. 3, 1918		6 AGE (IN YEARS LAST BIRTHDAY) 61 YRS		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unknown		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE N.J.		13b. COUNTY Hudson		13c. CITY OR TOWN Jersey City		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 93 Fairview Ave	
14 FATHER'S NAME FIRST MIDDLE LAST Halvor Jacobsen					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa Olsen				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 157-05-6846		17 INFORMANT ADDRESS Harold Jacobsen 20 Milton Avenue Stanhope, N.J.			

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), or (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest 4414 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pulmonary embolism (c) Pelvic vein thrombosis DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) ① RENAL FAILURE ② GANGRENE FEET - 2° CEN. 750							
19a. DATE OF OPERATION 2/23/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED arteriosclerotic obstructions		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW AND WHERE OCCURRED (GIVE NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/19 , 19 80 , to 3/7 , 19 80 , that (I) (we) last saw the deceased alive on 3/7 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Kenneth Cruze, M.D.				DEGREE M.D.		22c. DATE SIGNED 3/7/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kenneth Cruze, M.D.				22e. ADDRESS 831 University Blvd. #29 Silver Spring Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-11-80		23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Staten Island New York	
24 FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND				25a. DATE REC'D. BY REGISTRAR MAR 11 1980		25b. REGISTRAR'S SIGNATURE L. H. McCreedy	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
<div> <div>FOR STATE REGISTRAR</div> <div>0 7 8 6 6</div> <div>REG. NO.</div> </div>											
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE KNOWN OF DEATH					
FIRST MIDDLE LAST						MONTH DAY YEAR					
KITTIE E. JACKSON						3 31 1980					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR		IF UNDER 24 HRS.	
female		black		MONTH DAY YEAR		LAST BIRTHDAY		MONTHS		DAYS	
				MAY 10 1905		74 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)						7b. CITIZEN OF WHAT COUNTRY?					
Virginia						U.S.A.					
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION					
Silv Spr Md						Holy Cross Hosp Silv Spr Md.					
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY					
Housewife						Private					
13a. STATE						13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md						Mont		Silv Spr		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS						15. MOTHER'S MAIDEN NAME					
12212 Holdridge Rd						Mary Watson					
14. FATHER'S NAME						16a. WAS DECEASED EVER IN U.S. ARMED FORCES?					
Robert Overton						(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					
16b. SOCIAL SECURITY NO.						17. INFORMANT					
No						429-40-3263					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a)						Pulmonary embolism					
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.						Fracture of ankle					
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
None											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
3-11-80				Fracture of ankle				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				HOUR A.M. MONTH DAY YEAR							
				P.M. 3:3 1980				Slipped on ice			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION			
				Home				Street City or Town County State			
				Holdridge Rd S-Lidge Mount Md							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE						TITLE (SPECIFY)					
[Signature]						M.D. Dep					
EXAMINER'S NAME (TYPE OR PRINT)						MEDICAL EXAMINER					
ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION	
Removal				Apr. 4, 80						CITY OR TOWN COUNTY STATE	
										Louisia, Virginia	
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR					
NAME ADDRESS						DATE					
McGuire Funeral Service, 7400 Georgia Ave NW, Wash.						APR 10 1980					
						25b. REGISTRAR'S SIGNATURE					
						[Signature]					

1. The first part of the document is a list of names and addresses, which are arranged in a columnar fashion. The names are written in a cursive hand, and the addresses are written in a more formal, printed style. The list is headed by the word "List" in a large, bold font.

2. The second part of the document is a series of paragraphs of text, which are arranged in a columnar fashion. The text is written in a cursive hand, and the paragraphs are separated by small gaps. The text is headed by the word "Text" in a large, bold font.

3. The third part of the document is a series of paragraphs of text, which are arranged in a columnar fashion. The text is written in a cursive hand, and the paragraphs are separated by small gaps. The text is headed by the word "Text" in a large, bold font.

4. The fourth part of the document is a series of paragraphs of text, which are arranged in a columnar fashion. The text is written in a cursive hand, and the paragraphs are separated by small gaps. The text is headed by the word "Text" in a large, bold font.

5. The fifth part of the document is a series of paragraphs of text, which are arranged in a columnar fashion. The text is written in a cursive hand, and the paragraphs are separated by small gaps. The text is headed by the word "Text" in a large, bold font.

6. The sixth part of the document is a series of paragraphs of text, which are arranged in a columnar fashion. The text is written in a cursive hand, and the paragraphs are separated by small gaps. The text is headed by the word "Text" in a large, bold font.

7. The seventh part of the document is a series of paragraphs of text, which are arranged in a columnar fashion. The text is written in a cursive hand, and the paragraphs are separated by small gaps. The text is headed by the word "Text" in a large, bold font.

8. The eighth part of the document is a series of paragraphs of text, which are arranged in a columnar fashion. The text is written in a cursive hand, and the paragraphs are separated by small gaps. The text is headed by the word "Text" in a large, bold font.

9. The ninth part of the document is a series of paragraphs of text, which are arranged in a columnar fashion. The text is written in a cursive hand, and the paragraphs are separated by small gaps. The text is headed by the word "Text" in a large, bold font.

10. The tenth part of the document is a series of paragraphs of text, which are arranged in a columnar fashion. The text is written in a cursive hand, and the paragraphs are separated by small gaps. The text is headed by the word "Text" in a large, bold font.



11. The eleventh part of the document is a series of paragraphs of text, which are arranged in a columnar fashion. The text is written in a cursive hand, and the paragraphs are separated by small gaps. The text is headed by the word "Text" in a large, bold font.

12. The twelfth part of the document is a series of paragraphs of text, which are arranged in a columnar fashion. The text is written in a cursive hand, and the paragraphs are separated by small gaps. The text is headed by the word "Text" in a large, bold font.

13. The thirteenth part of the document is a series of paragraphs of text, which are arranged in a columnar fashion. The text is written in a cursive hand, and the paragraphs are separated by small gaps. The text is headed by the word "Text" in a large, bold font.

14. The fourteenth part of the document is a series of paragraphs of text, which are arranged in a columnar fashion. The text is written in a cursive hand, and the paragraphs are separated by small gaps. The text is headed by the word "Text" in a large, bold font.

15. The fifteenth part of the document is a series of paragraphs of text, which are arranged in a columnar fashion. The text is written in a cursive hand, and the paragraphs are separated by small gaps. The text is headed by the word "Text" in a large, bold font.

16. The sixteenth part of the document is a series of paragraphs of text, which are arranged in a columnar fashion. The text is written in a cursive hand, and the paragraphs are separated by small gaps. The text is headed by the word "Text" in a large, bold font.

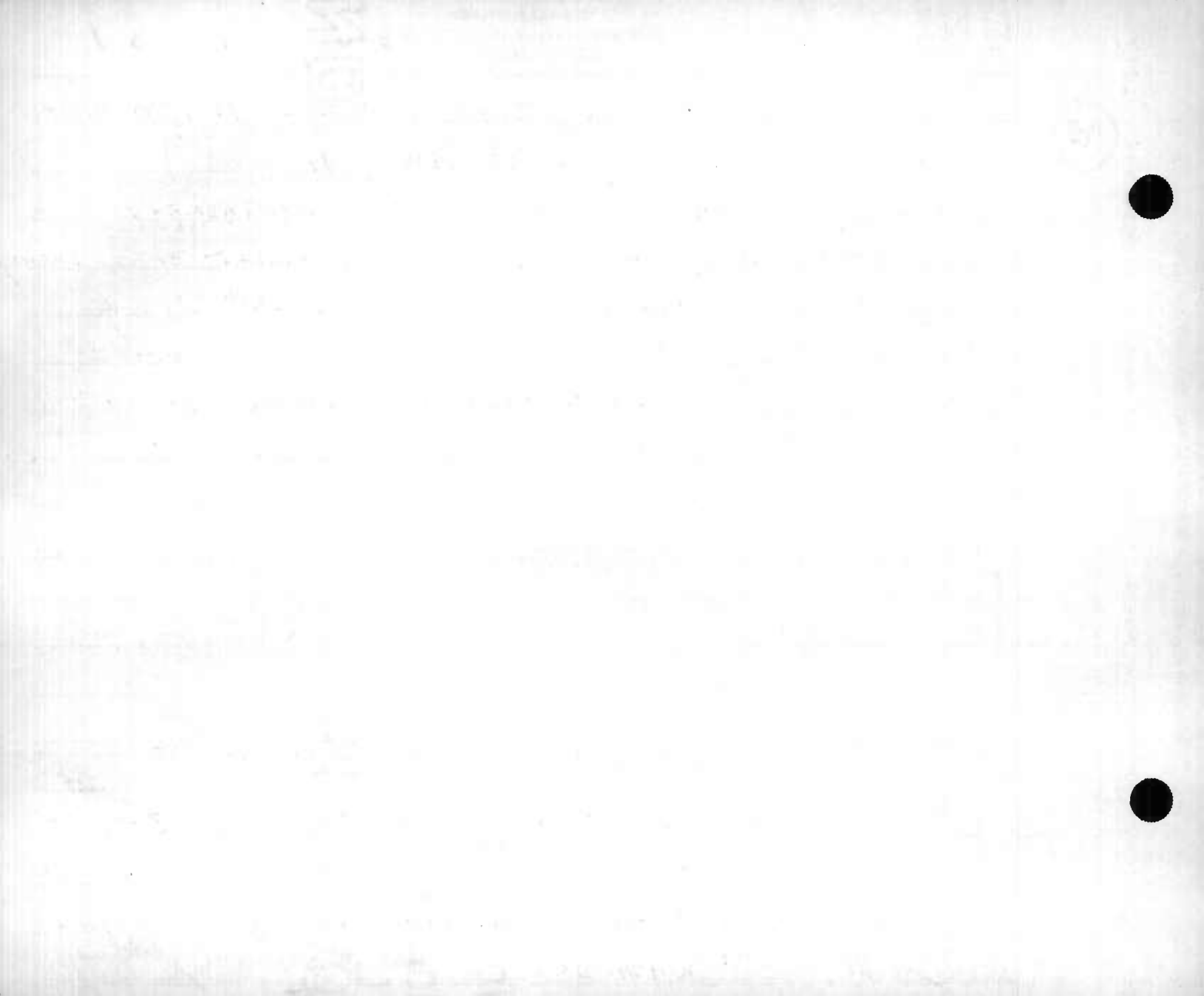
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0 0 7 8 6 7			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANK William LEWELLYN JAMES				2a. DATE OF DEATH MONTH DAY YEAR MARCH 16, 1980		2b. HOUR 4:15 P.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 28 1888		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 91	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ENGLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BROOKMONT		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6504 BROOKES HILL COURT		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNTANT		12b. KIND OF BUSINESS OR INDUSTRY BRITISH EMBASSY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE —		13b. COUNTY —		13c. CITY OR TOWN WASHINGTON D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WAITER HENRY JAMES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JESSIE MOORE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 564 46 6170	
17. INFORMANT ADDRESS GLADYS P. JAMES (DAUGHTER) SAME AS #11		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Aspiration Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) LUNG CANCER DUE TO, OR AS A CONSEQUENCE OF (c) —		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HOUR		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) —	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (1) (this hospital) attended the deceased from July 19 74 to MARCH 16 19 80 , that (1) (we) last saw the deceased alive on MARCH 13 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death)		22b. SIGNATURE DEGREE Gray P. Fisher MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED 3-16-80		22d. PHYSICIAN'S NAME (TYPE OR PRINT) GRAY P Fisher		22e. ADDRESS 5530 WISC. AVE CHERRY CHASE, MD.		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION 23b. DATE 3-17-80 23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE FAIR FAX Virginia	
24. FUNERAL DIRECTOR NAME DeVol Funeral Home ADDRESS WASH. D.C.		25a. DATE REC'D. BY REGISTRAR MAR 24 1980		25b. REGISTRAR'S SIGNATURE Anthony McNeely		BP	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of page.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bruno B. Janowski			2a. DATE OF DEATH MONTH DAY YEAR 3 10 80			2b. HOUR 6P M	
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR May 16 1904		6. AGE (IN YEARS LAST BIRTHDAY) 75(?) YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery. MD.	
10. CITY OR TOWN OF DEATH Takoma Park.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Janitor.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland.		13b. COUNTY Prince Geo.		13c. CITY OR TOWN E. Riverdale.		13d. STREET ADDRESS 5602 Kennedy St. # 202	
14. FATHER'S NAME FIRST MIDDLE LAST Janowski.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NOT AVAILABLE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 578-24-4120		17. INFORMANT College Park. A. Bruce D. Feltner. 5113 Lackwana			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory failure 5990 DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Vascular embolism PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Carcinoma of Esophagus							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/13 , 19 80 to 3/10/80 , that (I) (we) lost saw the deceased alive on 3/10/80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. Brown, M.D.				DEGREE M.D.		22c. DATE SIGNED 3/10	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 13 1980		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore B.D. MD	
24. FUNERAL DIRECTOR NAME Arthur Waters				25a. DATE REC'D. BY REGISTRAR MAR 17 1980		25b. REGISTRAR'S SIGNATURE Walter Kennedy	

Washington, D.C.

1944

Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation, Washington, D.C.

Dear Sir:

Reference is made to your letter of the 10th instant regarding the above captioned matter.

The Bureau is currently conducting an investigation of the activities of the [redacted] and the results of this investigation will be reported to you as soon as they are available.

Very truly yours,
[Signature]
Special Agent in Charge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 007869			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Emily JOHNSON				March 11 1980 10:55 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 18, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN) Madison Wisc.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery, MD.	
10. CITY OR TOWN OF DEATH Takoma Park.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Federal Govern. Retired.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE D.C. 13b. CITY OR TOWN Takoma Park				13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 527 Fern Pl. N. W. D. C.	
14. FATHER'S NAME FIRST MIDDLE LAST Eugene Rowley.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Laura Smith.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 579-60-2884		17. INFORMANT ADDRESS Edwin D. Johnson. (13 e)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 RIGHT CEREBRAL INFARCT. CEREBRAL EMBOLUS DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE AND ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Dec 1974 to March 11 1980, that (I) (we) lost saw the deceased alive on March 11 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert L. Krichmar		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED March 11 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT L. KRICHMAR		22e. ADDRESS 7733 ALASKA AVENUE N.W. WASHINGTON D.C. 20002					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 13-1980		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR Arthur Waters		25a. DATE REC'D. BY REGISTRAR MAR 17 1980		25b. REGISTRAR'S SIGNATURE [Signature]			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										07870	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE KNOWN OF DEATH		2b. HOUR		3. 26 19 80	
Joseph J. Johnson						3. 26 19 80		3. 26 19 80		3:10A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 24 YRS.		7. IF UNDER 24 HRS.	
Male		White		5 24 26		53 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED	
West Virginia		USA		MARRIED		NEVER MARRIED		WIDOWED		DIVORCED	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13. STREET ADDRESS		14. FATHER'S NAME	
Bethesda		Suburban Hospital		Washington Gas Light Co.				3902 Joliet Street		James A. Johnson	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		15. MOTHER'S MAIDEN NAME	
Maryland		Montgomery		Wheaton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3902 Joliet Street		Unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
yes		WW II		235 38 4943		Mildred A. Johnson same as 13e		PART I DEATH WAS CAUSED BY:			
								IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u>			
								DUE TO, OR AS A CONSEQUENCE OF			
								(b)			
								DUE TO, OR AS A CONSEQUENCE OF			
								(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				HOUR A.M. MONTH DAY YEAR							
				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>								STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
				M.D. Assistant MEDICAL EXAMINER				3/26/80			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Ann M. Dixon, M.D.				111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial				3/29/80		Gate of Heaven Cemetery		CITY OR TOWN COUNTY STATE			
								Silver Spring, Maryland			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
NAME											
Tyson Wheeler Funeral Home, Inc.											
1331 Rockville Pike Rockville, Maryland											
				APR 2 1980							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 07871			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 3-23-80			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST (BABY) MARY JOHNSON				2b. HOUR 7:15 am			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3-23-80		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS 1 45	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH SIL. SPR.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Takoma Park				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7611 Maple Avenue #306	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ava D. Johnson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Ava D. Johnson Same as item 13 a-e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 7798							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. 45 min.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) severe prematurity (23 week gestation)							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature] DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-23-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANK A. PEDREIRA				22e. ADDRESS 19251 Montgomery Village Ave.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-31-80		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION Silver Spring Maryland	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc., 1331 Rockville Pike Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR APR 3 1980		25b. REGISTRAR'S SIGNATURE [Signature]	

1 2

Jack - 1910

Montgomery - 1910

Montgomery - 1910

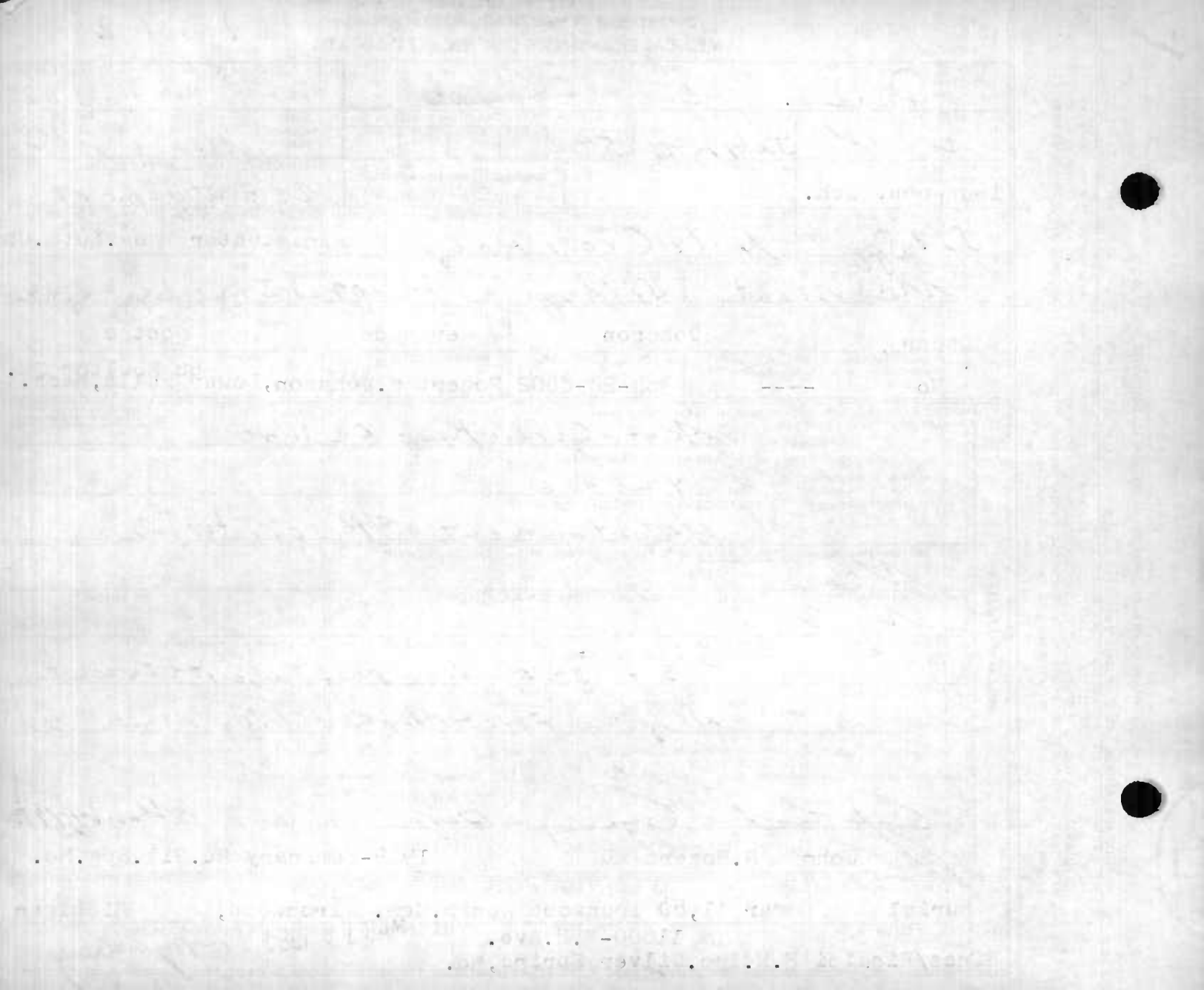
Unknown - 1910

Unknown - 1910

1910 - 1910

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										07872	
FOR 1. STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Paul L. Johnson						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR MAR 4 1980		2b. HOUR 12:30 PM			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR July 26 25 54		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN. 54 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD March 4 1980	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ironwood, Mich.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Sil. Spg.				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrator		12b. KIND OF BUSINESS OR INDUSTRY Aug. Luth. Ch.	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Mont 13c. CITY OR TOWN Sil. Spg.				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 10921 Inwood Ave. Apt 420					
14. FATHER'S NAME FIRST MIDDLE LAST Oscar Johnson						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Goethe					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 384-28-8802		17. INFORMANT ADDRESS 66 Moulton St. Robert M. Johnson, Lower Falls, Mass.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardio Resp. Failure 8768 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) A20112 DUE TO, OR AS A CONSEQUENCE OF (c) Detachment of Respiratory Tube										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR P.M. 3 4 1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Pulled Resp. Tube off Tracheal tube					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Hospital Forest Glen Md.		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Sil. Spg. Mont Md					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers				TITLE (SPECIFY) Dep.				DATE SIGNED March 4 1980			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers MD				ADDRESS 1919-Seminary Rd. Sil. Spg. Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Mar 11, 80		23c. NAME OF CEMETERY OR CREMATORY Ironwood Munip. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Ironwood, Michigan			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi				ADDRESS F.H. Inc. Silver Spring, Md.				25a. DATE Mar 10 1980 25b. REGISTRAR'S SIGNATURE John S. Rogers			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 0 7 8 7 3

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Roy B. Johnson		2a. DATE OF DEATH MONTH DAY YEAR March 6, 1980	
3 SEX Male		2b. HOUR A. 1:40 M	
4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Aug. 9, 1891	
6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	
8 CITIZEN OF WHAT COUNTRY? USA		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rockville Nursing Home	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Self Employed	
13a. STATE Maryland		13b. COUNTY Montgomery	
13c. CITY OR TOWN Sil. Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 203 Williamsburg Drive,		14 FATHER'S NAME FIRST MIDDLE LAST Harry C. Johnson	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie L. Louderman		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	
16b. SOCIAL SECURITY NO 220-22-4357		17 INFORMANT (daughter) ADDRESS Ruth Johnson (same as 13e)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>CVP and chronic brain syndrome</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. LOCATION STREET CITY OR TOWN COUNTY STATE		21f. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22a. I certify that (I) (this hospital) attended the deceased from <u>5/26</u> , 19 <u>77</u> , to <u>3/5</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>3/5</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>[Signature]</u> DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>3/6/1980</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>KWANG S. KIM</u>		22e. ADDRESS <u>615 W. Montgomery Ave. Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE <u>3-6-80</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Metropolitan</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Alexandria Fairfax Va.</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> <u>8434 Georgia Ave., S.S. Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>MAR 11 1980</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL-SEE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				07874			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carroll VINCENT JONES				2a. DATE OF DEATH MONTH DAY YEAR March 09 1980		2b. HOUR 2:29 PM	
3 SEX male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 8 05 98		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10 CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. U.S. GOVT.		12b. KIND OF BUSINESS OR INDUSTRY PARK & PLANNING	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.				13b. CITY OR TOWN SILVER SPRING		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST CHARLES B. JONES				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH TRAIL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO 215-26-3154		17 INFORMANT ADDRESS MILDRED E. JONES (SAME AS 13e)			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Complete Heart block</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary atherosclerosis</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 Days 2 mos. years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) EMPHYSEMA AND CHRONIC BRONCHITIS. HEPATOMEGALY, CHRONIC							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>MAY 20, 1954</u> to <u>MARCH 9, 1980</u> , that (1) (we) lost saw the deceased alive on <u>MARCH 9, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE James A. Roberts, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED MARCH 9, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES A. ROBERTS				22e. ADDRESS 8907 GEO. AVE. SILVER SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-12-80		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTG. MD.	
24 FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES P/A				ADDRESS ROCKVILLE MD.		25. DATE REC'D. BY REGISTRAR 1980 25. REGISTRAR'S SIGNATURE	

TO: THE ATTORNEY GENERAL
FROM: THE ATTORNEY GENERAL
SUBJECT: [Illegible]

RE: [Illegible]

[Illegible text block]

[Illegible text block]

[Illegible text block]

[Illegible text block]

1202 BP _____
DHMH - 17
(VR A15 ME (5))
15M 7/77

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after burial, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR STATE REGISTRAR

2- MEDICAL CERTIFICATION

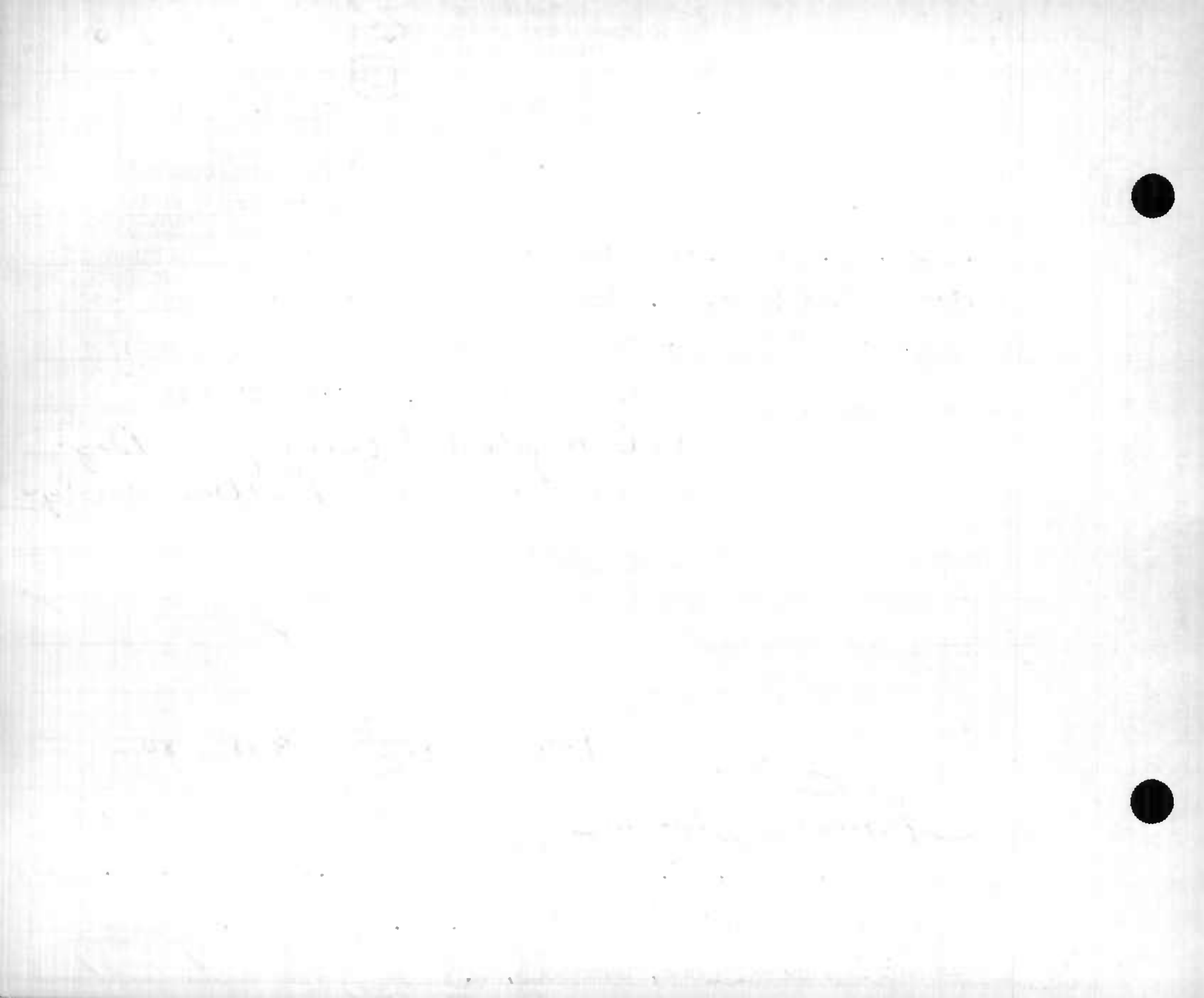
3- TO FUNERAL DIRECTOR

4- TO HOSPITAL OR ATTENDING PHYSICIAN

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eva A. JOSLIN			2a. DATE OF DEATH MONTH DAY YEAR March 18, 1980			2b. HOUR P M 10 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 1 1898		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Mt. Airy, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9020 Brown Church Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Housewife	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Parker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora (unknown)		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 208 24 9423		17. INFORMANT ADDRESS Forest C. Joslin Item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial disease 4249 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic valvular atherosclerotic heart disease over 5 yrs. DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1-3 , 19 80 , to 3-18 , 19 80 , that (I) (we) lost saw the deceased alive on 3-4 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Thomas P. Sloan, MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/19/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas P. Sloan, MD.				22e. ADDRESS 9701 Church St., Damascus, Md. 20750			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/19/80		23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Pk., Baltimore, Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Molesworth Funeral Home, Damascus, Md.				25a. DATE RECD. BY REGISTRAR 3/19/80			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) Eva EVA				2a. DATE OF DEATH 3 Month 2 Day 80 Year				2b. HOUR 7:05 AM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JULY 18, 1892			6. AGE (In years last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY				
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) POTOMAC NURSING HOME			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MERCHANT			12b. KIND OF BUSINESS OR INDUSTRY RETAIL		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission), STATE PENNSYLVANIA		13b. COUNTY PHILADELPHIA		13c. CITY OR TOWN PHILADELPHIA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2601 PARKWAY		
14. FATHER'S NAME First Middle Last JOSEPH BRANDENBURG				15. MOTHER'S MAIDEN NAME First Middle Last HANNAH (UNASCERTAINABLE)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO		16b. SOCIAL SECURITY NO. 202-01-1120		17. INFORMANT **)* 8808 TUCKERMAN LANE, DR. BERNARD SCHWARTZMAN, POTOMAC, MARYLAND						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Emphysema 492- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) congestive heart failure										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (1) this hospital attended the deceased from 8-26, 1979 , to 3-2, 1980 , that (1) (we) last saw the deceased alive on 2-24, 1980 , and that in (my) (our) apinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE James Brodsky MD				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-2-80		
22d. PHYSICIAN'S NAME (Type) James Brodsky MD				22e. ADDRESS 4701 Willard Ave Chevy Chase Md 20015						
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		23b. DATE MAR. 4, 1980		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW CONGREGATION CEMETERY			23d. LOCATION (City or Town) (County) (State) BALTIMORE, BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME				25a. REC'D BY REGISTRAR MAR 6 1980		25b. REGISTRAR'S SIGNATURE Anthony McKeon				
232 CARROLL STREET, N. W., WASHINGTON, D. C.										

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Items 18&22a G542 4/25/80 dad STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

07878

1. DECEASED NAME (TYPE OR PRINT) Harminderpal S. Kang			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3 26 19 80			2b. HOUR M	
3. SEX Male	4. RACE Indian	5. DATE OF BIRTH MONTH DAY YEAR 1-30-80	6. AGE (IN YEARS) LAST BIRTHDAY YRS. 1	IF UNDER 1 YR. MONTHS DAYS 26	IF UNDER 24 HRS. HOURS MIN. 	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 26 19 80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville	
14. FATHER'S NAME FIRST MIDDLE LAST Mohinder S. Kang				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harlovleen Grewal			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS Mohinder S. Kang same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spongy cortical atrophy (Alper's disease) 7428 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 3/26/80	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn St. Balto., MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/28/80		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria		23d. LOCATION CITY OR TOWN COUNTY STATE Virginia	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes				25. DATE REC'D. BY REGISTRAR APR 2 1980			
26. REGISTRAR'S SIGNATURE 							

BP

DHMH - 17
VR A15 ME (5)
15M 7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1-20-61

1-20-61

WA

Montgomery Rockville

Montgomery Rockville

Montgomery Rockville

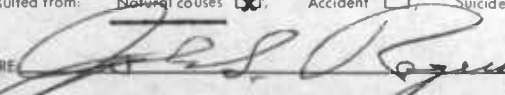
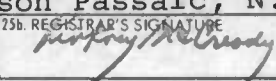
WA

Rockville, Maryland
Robert A. Montgomery Funeral Home
3120 14th St.
Rockville, Maryland

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

07879

1. DECEASED NAME (TYPE OR PRINT) Zina Kapeluch			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 3/14 19 80			2b. HOUR M		
3. SEX Female	4. RACE Cau	5. DATE OF BIRTH MONTH DAY YEAR Oct 21 1904	6. AGE (IN YEARS) LAST BIRTHDAY 75 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN 75	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN 75	2c. DATE PRONOUNCED DEAD 3/14 19 80		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 200 Briggs Rd				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY own home
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Sil. Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 2004 Briggs Road		
14. FATHER'S NAME FIRST MIDDLE LAST Unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 158-16-7435 197 10 9467		17. INFORMANT ADDRESS Walter Lissiuk (same as 13e)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 1889 IMMEDIATE CAUSE (a) Carcinoma of the bladder. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None								
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE 		TITLE (SPECIFY) Deputy M.D.			MEDICAL EXAMINER		DATE SIGNED 3/14/80	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.		ADDRESS Silver Spring, Montgomery, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-18-80		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Patterson Passaic, N. J.		
24. FUNERAL DIRECTOR Warner E. Pumphery ADDRESS 8434 Ga. Ave. Silver Spring, Md. 20910				25a. DATE RECEIVED BY REGISTRAR MAR 19 1980		25b. REGISTRAR'S SIGNATURE 		

Carcinoma of the bladder.

1520

None

УПОД

9 no 1

✕

Deputy

3/2-218

Silver Spring, Monticorey, Md.

John S. Rogers, M.D.

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Julius Karp			2a DATE OF DEATH MONTH DAY YEAR 3/4/80			2b HOUR 6:47P M					
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 8 22 1901		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7a IF UNDER 1 YEAR MONTHS DAYS 78		7b IF UNDER 74 HRS HOURS MIN. 78	
7c BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7d CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH Takoma Park			11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baker			12b KIND OF BUSINESS OR INDUSTRY Retired		

13a STATE Maryland			13b COUNTY P. G.			13c CITY OR TOWN Chillum			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS 703 Somerset Place		
14 FATHER'S NAME FIRST MIDDLE LAST Abraham Karp						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther Lerner								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO. 043-05-4859A				17 INFORMANT ADDRESS Ms. Estelle R. Wolper 8771 Contee Rd. Apt. 303 Maryland 20811						

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPOGLYCEMIA 2500 DUE TO, OR AS A CONSEQUENCE OF (b) ANOREXIA DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:
PULMONARY TUBERCULOSIS TREATED - ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 1 Feb 19 80 to 4 MAR 19 80 , that (I) (we) lost saw the deceased alive on 28 Feb 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do not) view the body after death.							
22b SIGNATURE Monica Fogarty				22c DATE SIGNED 4 Mar 80		22d ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e PHYSICIAN'S NAME (TYPE OR PRINT)				22f ADDRESS			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 3/6/1980		23c NAME OF CEMETERY OR CREMATORY KING DAVID MEM. GARDEN		23d LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH, VIRGINIA	
24 FUNERAL HOME NAME DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME				25 DATE RECEIVED BY REGISTRAR MAR 10 1980			
26 ADDRESS 232 CARROLL STREET, N.W., WASHINGTON, D. C.				27 REGISTRAR'S SIGNATURE H. J. McCreedy			

TO HOSPITAL ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

0 0 7 8 8 1

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) RACHEL BERNAN KASSEL			2a. DATE OF DEATH MONTH 3 DAY 8 YEAR 80			2b. HOUR 1:45 AM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 04 DAY 16 YEAR 26		6. AGE (IN YEARS LAST BIRTHDAY) 53			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. CITY OR TOWN Montgomery		13c. STREET ADDRESS Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

14. FATHER'S NAME FIRST Max MIDDLE Bernan LAST Bernan		15. MOTHER'S MAIDEN NAME FIRST Rose MIDDLE Vova LAST Vova	
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-46-6005		17. INFORMANT Mrs. Shirley Karr		ADDRESS 3802 Palmira Lane Silver Spring, Maryland	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS	
DUE TO, OR AS A CONSEQUENCE OF (b) LYMPHANGITIC CARCINOMATOSIS IN LUNG		2 months	
DUE TO, OR AS A CONSEQUENCE OF (c) BREAST CARCINOMA		2 1/2 YEARS	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
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21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
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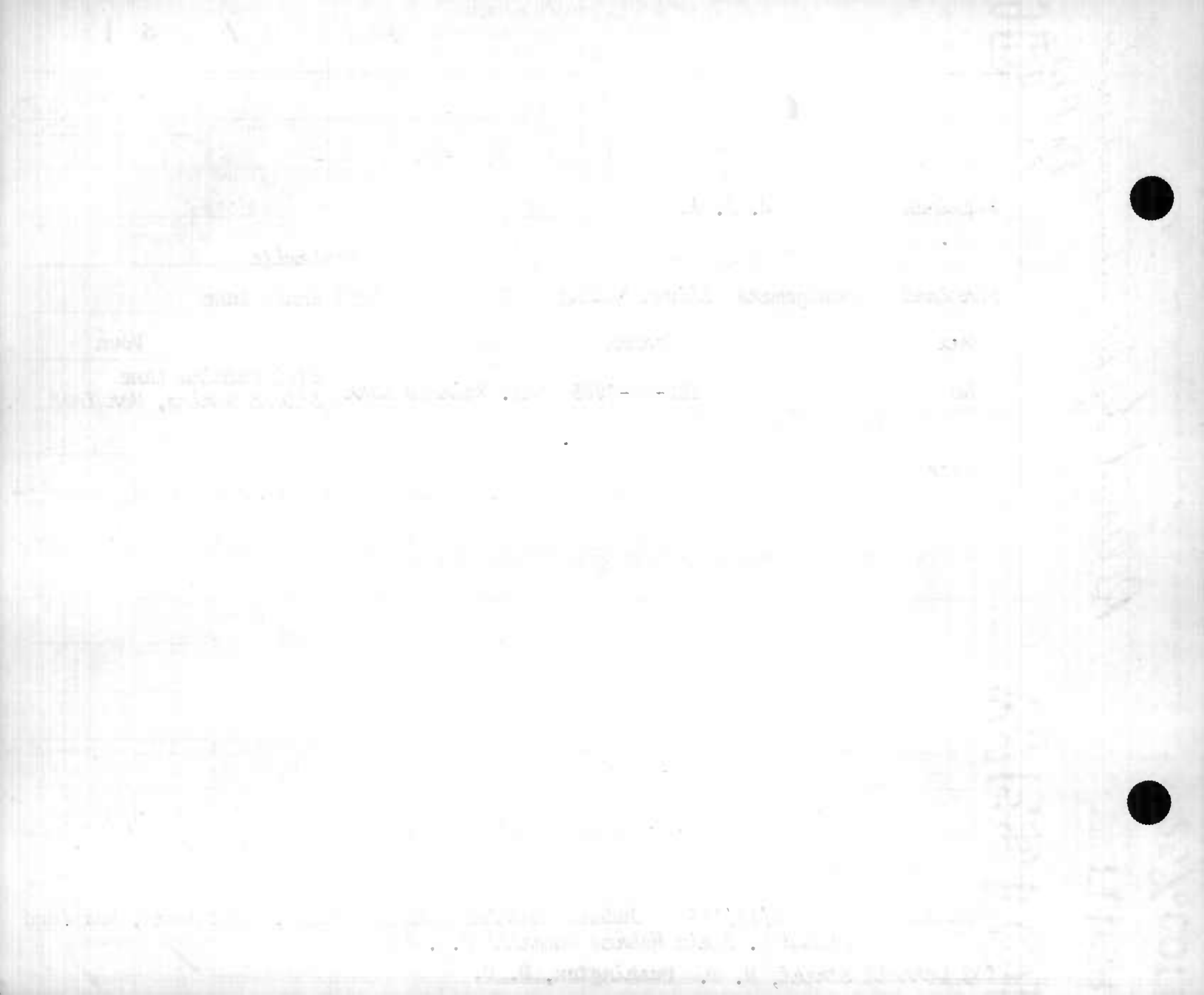
22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 19 78 to MARCH 8 19 80 , that (I) (we) last saw the deceased alive on MARCH 7 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
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22b. SIGNATURE Daniel Rosenblum		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/8/80	
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL ROSENBLUM		22e. ADDRESS 10400 CONNECTICUT AV KENSINGTON, MD 20795	
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23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 3/10/1980		23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Gardens		23d. LOCATION CITY OR TOWN Olney COUNTY Montgomery STATE Maryland	
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24. FUNERAL DIRECTOR NAME Donald M. Stein		ADDRESS Hebrew Memorial F.		CITY Washington, D. C.		25a. DATE OF DEATH 3/8/80		25b. REGISTRAR'S SIGNATURE [Signature]	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 07882			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 3/12/88 March 12, 1980			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mathilda Antoinette Kay				2b. HOUR 9:30 AM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 7/16/1900		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Scotland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired secretary		12b. KIND OF BUSINESS OR INDUSTRY Lock Co.	
13a. STATE Maryland				13b. STREET ADDRESS 1618 Marshall Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Sukis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Antoinette Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			
16b. SOCIAL SECURITY NO. 018 03 3109A		17. INFORMANT ADDRESS Gloria Peacock same as 13e		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST			
4140		DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 HOURS			
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 23 MAY 1979 to 12 MAR 1980, that (I) (we) saw the deceased alive on 28 NOV 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (I) (did not) view the body after death.							
22b. SIGNATURE Walter E. Goetz MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 13 MAR 80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOETZ MD				22e. ADDRESS 2309 SHOREFIELD ROAD WHEATON, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/17/80		23c. NAME OF CEMETERY OR CREMATORY Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE St. Petersburg, Florida	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc.				25a. DATE RECD. BY REGISTRAR 11 MAR 1980		25b. REGISTRAR'S SIGNATURE	
1331 Rockville Pike Rockville, Maryland 20852							

Enacted

Attention

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St. Petersburg, Florida

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

07883

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Samuel Issac Kelly			2a. DATE OF DEATH MONTH 3 DAY 11 YEAR 80			2b. HOUR 10 A M			
3. SEX Male		4. RACE BLACK		5. DATE OF BIRTH MONTH FEB. DAY 4 YEAR 1904		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY Montg		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST HENRY MIDDLE KELLY LAST KELLY			15. MOTHER'S MAIDEN NAME FIRST Annie MIDDLE DENT LAST DENT			13e. STREET ADDRESS 1400 Fenwick			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-16-0472		17. INFORMANT ADDRESS Mary Anna Kelly (wife) same as #13			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis 2500 DUE TO, OR AS A CONSEQUENCE OF Multiple Deep Abscesses DUE TO, OR AS A CONSEQUENCE OF Diabetic Mellitus - Uncontrolled									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerosis Generalized									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 12/19/79 , 19 79 , to 3/11/80 , 19 80 , that (I) (we) lost saw the deceased alive on 3/11/80 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE Howard W. Kennedy, M.D.			DEGREE M.D.			22c. DATE SIGNED 11 March '80		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Howard W. Kennedy, M.D.			22e. ADDRESS 1001 George St. Silver Spring, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3-15-80		23c. NAME OF CEMETERY OR CREMATORY Mutual Mem. Cem.		23d. LOCATION CITY OR TOWN Sandy Spring COUNTY Montg STATE Md.		
24. FUNERAL DIRECTOR NAME George R. Snowden			24b. ADDRESS 246 N. WASH. ST. Rockville, Md.			25a. DATE REC'D. BY REGISTRAR MAR 19 1980		25b. REGISTRAR'S SIGNATURE Henry K. Brady	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07884
REG. NO.

1- STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
FIRST MIDDLE LAST Herman S. Kerbel		male		white	
5. DATE OF BIRTH		6. AGE (IN YEARS)		7. DATE OF DEATH	
MONTH DAY YEAR Nov 10 1933		LAST BIRTHDAY 76 YRS		MONTH DAY YEAR 3-31-80	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
New York		U. S. A.		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Tr 6. Park		Washington Adventist Hospital		Self-Employed	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MD		Prince Georges		Hyattsville	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	
FIRST MIDDLE LAST Rudolph Kerbel		FIRST MIDDLE LAST Ida Evans		16b. SOCIAL SECURITY NO. 224-07-1822	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Mrs. Josephine Kerbel (Same as # 13)		PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Chronic myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) 4291		4 yr	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE	
John S. Rogers, M. D.		M.D. Dep.		March 31, 1980	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		1919 Seminary Road, Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		4/3/80		NATIONAL MEMORIAL PARK	
23d. LOCATION CITY OR TOWN		COUNTY		STATE	
FALLS CHURCH,		VIRGINIA			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
M. STEIN HEBREW MEMORIAL FUNERAL HOME		APR 7 1980		Turkey Hill	
232 CARROLL STREET, N.W., WASHINGTON, D. C.					

100-100000-100000
100-100000-100000

Report of Special Agent in Charge

Subject

Investigation conducted at

On or about 10-1-1964, at New York, New York

10-1-1964

Re New York letter to Bureau dated 10-1-1964

Re New York letter to Bureau dated 10-1-1964

Re New York letter to Bureau dated 10-1-1964

Re New York letter to Bureau dated 10-1-1964

Re New York letter to Bureau dated 10-1-1964

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Re New York letter to Bureau dated 10-1-1964

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Re New York letter to Bureau dated 10-1-1964

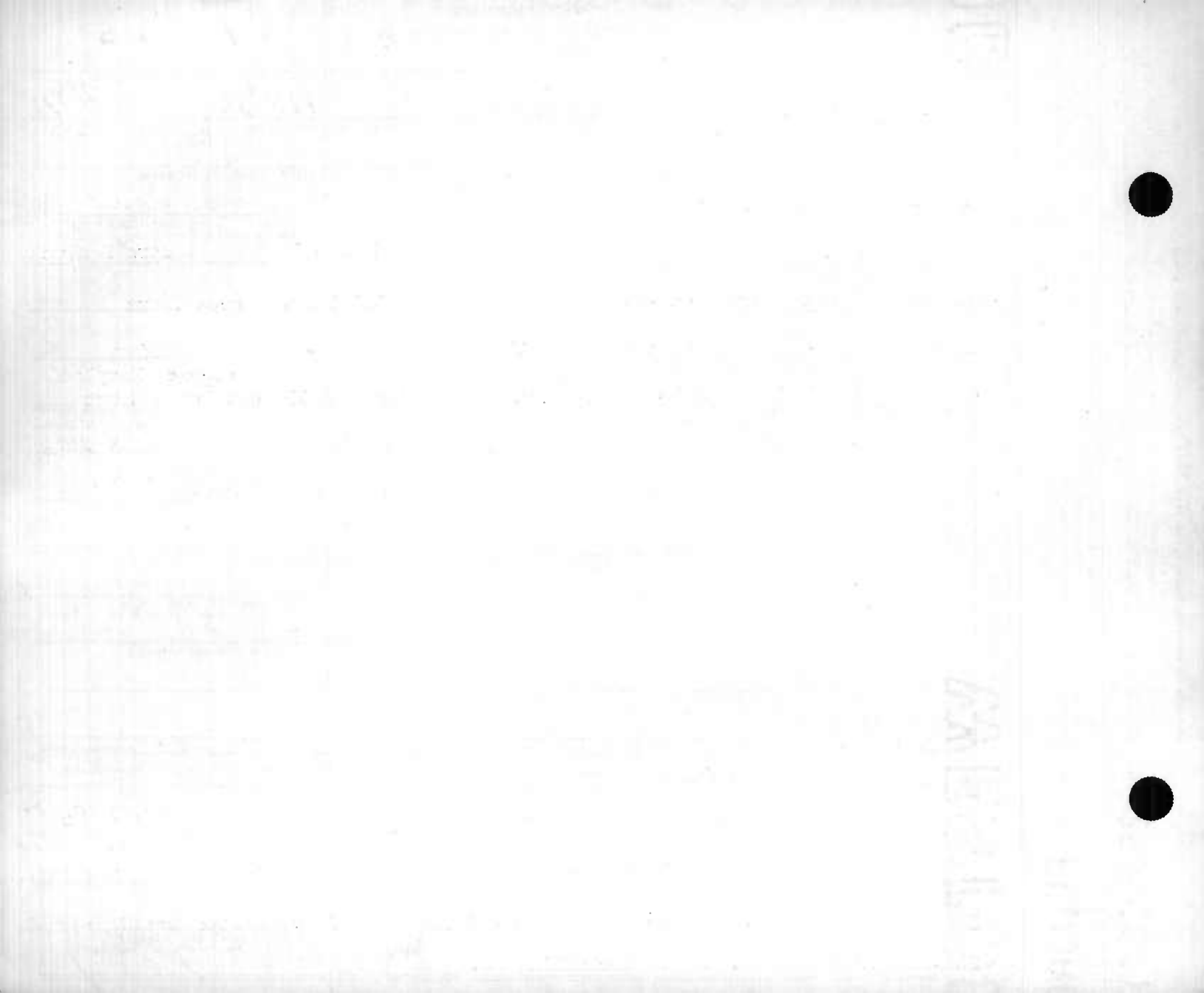
Re New York letter to Bureau dated 10-1-1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 07885			
1. DECEASED NAME (TYPE OR PRINT) ESTELLE KERN				2a. DATE OF DEATH MONTH DAY YEAR 3/17/80			
3 SEX Female		4 RACE C		5 DATE OF BIRTH MONTH DAY YEAR 4/19/29		6 AGE (IN YEARS LAST BIRTHDAY) 50 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical		12b. KIND OF BUSINESS OR INDUSTRY Sears Roebuck	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Herman ----- Mestel				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara ----- Weiss			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Potomac, Maryland			
		076-22-8549		Dr. Jerome Kern, 11117 Post House Court			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septic Shock						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 HRS	
0415 } DUE TO, OR AS A CONSEQUENCE OF (b) HEMOPHILUS INFLUENZA BACTEREMIA						3 DAYS	
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3-18 , 19 80 , to 3-17 , 19 80 , that (I) (we) lost saw the deceased alive on 3-17 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Herbert L. Tanenbaum DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/17/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Herbert L. TANENBAUM				22e. ADDRESS 5480 Wisconsin Ave NW Chevy Chase Md 20015			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 20, 1980		23c. NAME OF CEMETERY OR CREMATORY Judean Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Olney, Montgomery, Maryland	
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEM. CHAP., Rockville, Md. ADDRESS				25a. DATE REC'D BY REGISTRAR MAR 21 1980		25b. REGISTRAR'S SIGNATURE Notary McCreary	



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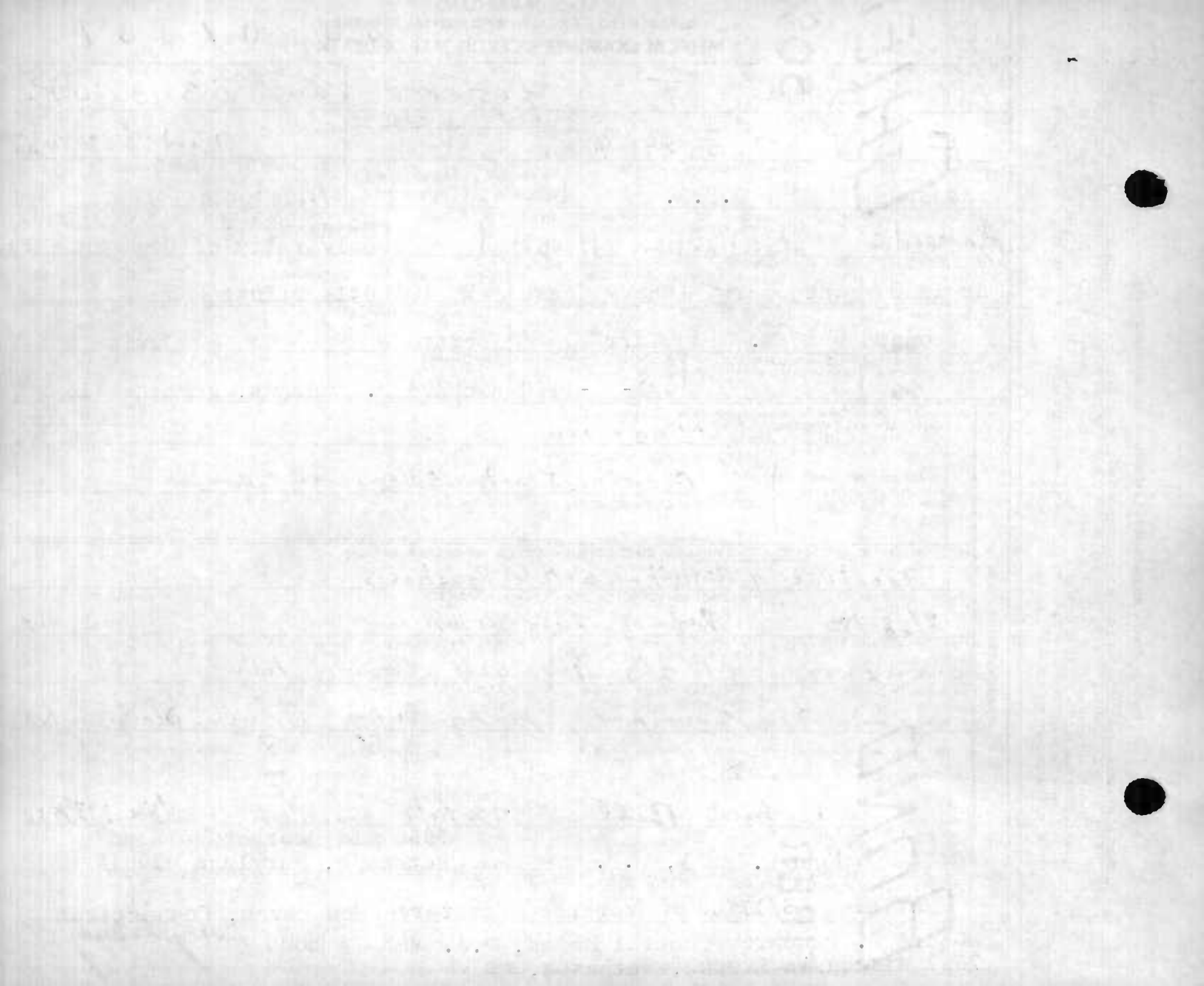
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										07887 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Lulia T Ketherer										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 3 DAY 13 YEAR 1980 2b. HOUR 4:45 AM	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH 7 DAY 5 YEAR 89	6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN 	2c. DATE PRONOUNCED DEAD March 13, 1980		2d. HOUR 4:45 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION OR TYPE OF WORK University of New Hampshire		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6411 Offutt Road			
14. FATHER'S NAME FIRST Leonard MIDDLE M. LAST Tarr				15. MOTHER'S MAIDEN NAME FIRST Gertrude MIDDLE LAST Davis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 001-26-1150		17. INFORMANT ADDRESS Richard D. Andrews, same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infection 4409 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) Generalized Arteriosclerosis - Severe (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Fracture of Rt Hip - Severe Psychosis											
19a. DATE OF OPERATION 2/28/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Repair of Fr. of Rt Hip						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7 P.M. 2-26-1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fall at running lane							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Running Home		21f. LOCATION STREET Kensington Gardens CITY OR TOWN Kensington COUNTY Montgomery STATE MD							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John G. Ball		TITLE (SPECIFY) M.D. DePoty				MEDICAL EXAMINER		DATE SIGNED March 13, 1980			
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D.		ADDRESS Bethesda, Maryland 20014									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/17/80		23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		23d. LOCATION CITY OR TOWN New Haven COUNTY Connecticut STATE 					
24. FUNERAL DIRECTOR Robert A. Pumphrey						25a. DATE REC'D. BY REGISTRAR MAR 24 1980		25b. REGISTRAR'S SIGNATURE [Signature]			
7557 Wisconsin Avenue, Bethesda, MD											



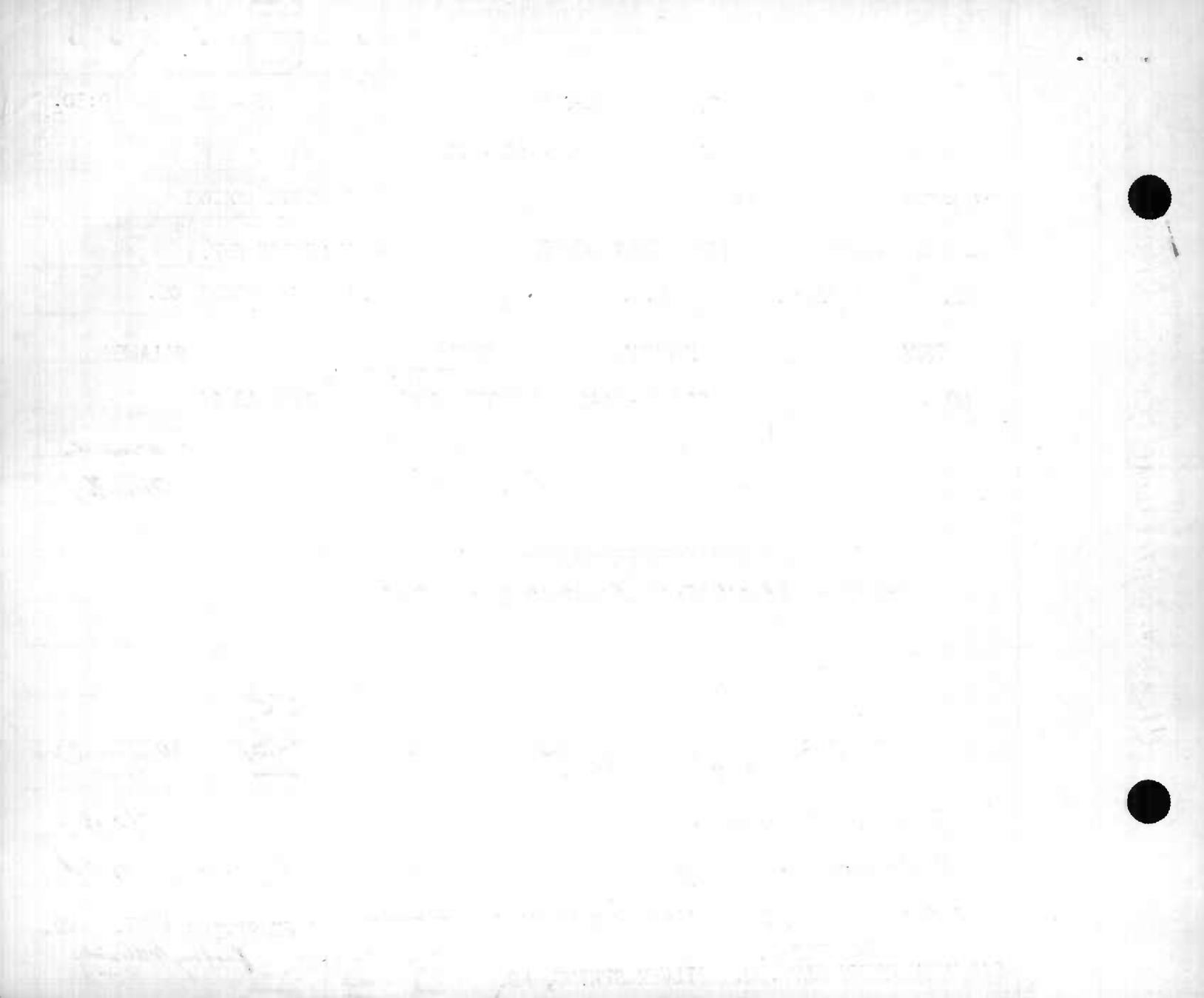
Cleared by Medical Examiner's Office

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #7a Film G569 7/2/82 rc				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 - 0 7 8 8 8					
1- STATE REGISTRAR				CERTIFICATE OF DEATH				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) KHADER			FIRST I.-			MIDDLE KHOURY			2a. DATE OF DEATH MONTH DAY YEAR 03 - 21 - 80			2b. HOUR 9:30 A.M.	
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR 03 - 01 - 13 ^{EAR}			6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PALESTINE			7b. CITIZEN OF WHAT COUNTRY? USA Jordan			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.				
10. CITY OR TOWN OF DEATH SILVER SPRING			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) POST OFFICE EMP.			12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.						13b. COUNTY MONT.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12608 ARBORVIEW CT.	
14. FATHER'S NAME FIRST MIDDLE LAST ISSA						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIA SALAMEH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO 214-90-8642			17. INFORMANT SISTER IN LAW			ADDRESS ANNETTE KURI SAME AS 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> 4280 DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>months</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>chronic obstructive pulmonary disease</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from <u>3/21</u> , 19 <u>80</u> , to <u>3/21</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>3/19</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Marian Chung M.D.</u>						DEGREE			22c. DATE SIGNED <u>3/21/80</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MARIAN CHUNG, M.D.</u>						22e. ADDRESS <u>344 University Blvd. W. Silver Spring, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE MAR. 24, 1980			23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY			23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT. MD.				
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR MAR 26 1980			25b. REGISTRAR'S SIGNATURE <u>Jeffrey Halvord</u>				
500 UNIVERSITY BLVD., W. SILVER SPRING, MD.													

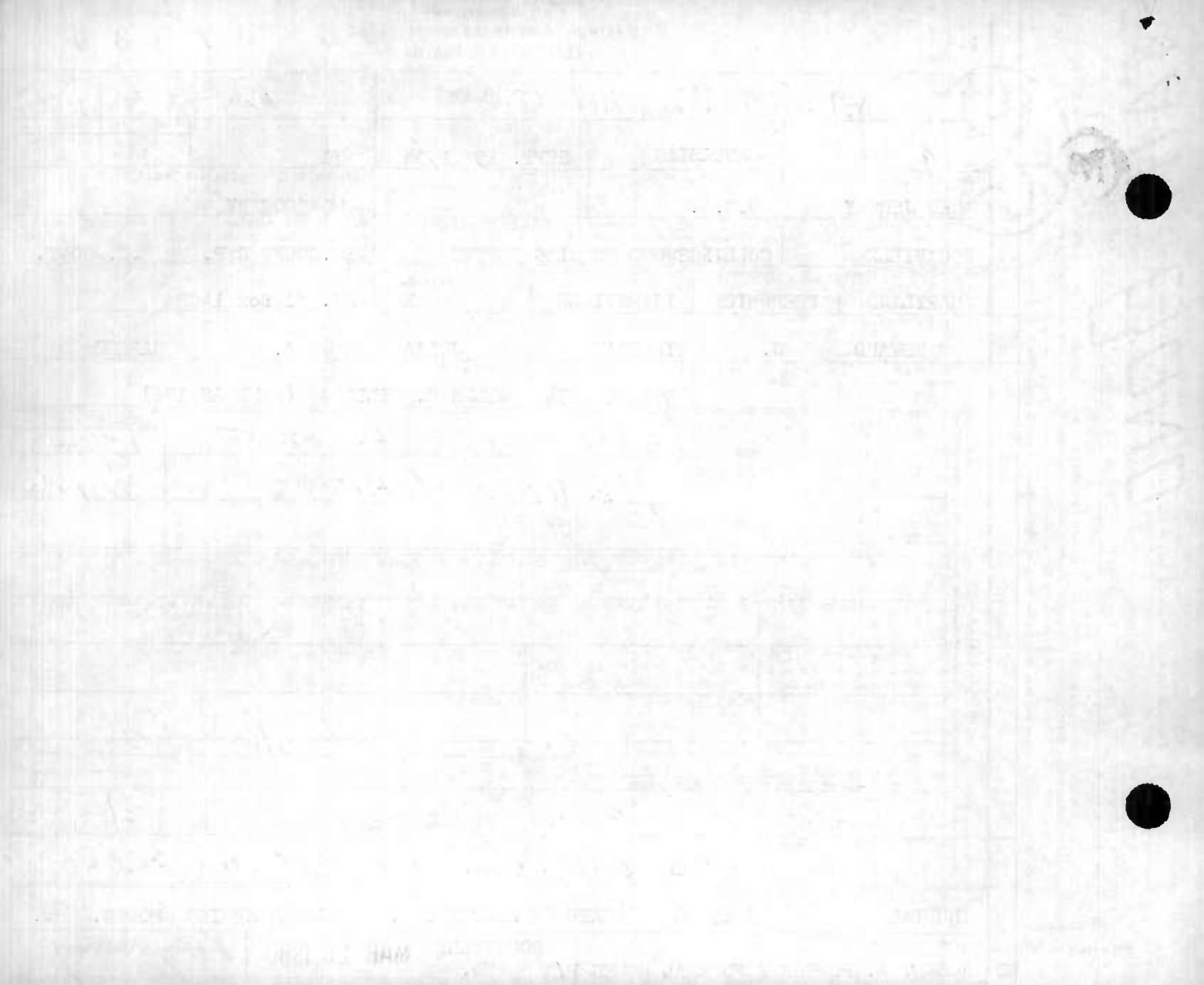


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 0 7 8 8 9						
1. DECEASED NAME (TYPE OR PRINT) MILLIAM John KILLORAN			2a. DATE OF DEATH MONTH DAY YEAR MAR 12 80			2b. HOUR 1100 P.M.			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR SEPT. 15 1908		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) COLLINGSWOOD NURSING CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. COURT REP.		12b. KIND OF BUSINESS OR INDUSTRY D.C. GOVT.	
13a. STATE MARYLAND		13b. COUNTY FREDERICK		13c. CITY OR TOWN IJAMSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RT. #1, Box 140D	
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD J. KILLORAN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JULIA A. HARRER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 091-01-1254		17. INFORMANT ADDRESS HELEN C. KILLORAN (SAME AS 13e)					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CAROTID VASCULAR ACCIDENT</u> 436- DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YEAR YEARS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>OCT 3/10</u> 19 <u>79</u> to <u>3/12</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>3/10</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.									
22b. SIGNATURE Thos G. WARD, 6116 Reisterstown Rd, Baltimore, Md 21038				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/13/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. WARD				22e. ADDRESS 6116 Reisterstown Rd, Baltimore, Md 21038					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-15-80		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTG. MD.			
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES P/A		ADDRESS ROCKVILLE MD.		25a. DATE REC'D. BY REGISTRAR MAR 19 1980		25b. REGISTRAR'S SIGNATURE [Signature]			



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) Glenn Kilpatrick		MONTH DAY YEAR 03 02 80		3:48 P.M.	
3. SEX Male	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 12 17 22		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) UTAH	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FOOD DRUG OFFICER		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN ROCKVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ANDY J. KILPATRICK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDELLA TURNER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW II		16b. SOCIAL SECURITY NO. 529-14-6973		17. INFORMANT ADDRESS JOY HALL KILPATRICK SAME AS 13 WIFE	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Anoxia 4-10- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute M.I. (c) Cerebral Artery Disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/24/80 to 3/2/80 , that (I) (we) lost saw the deceased alive on 3/24/80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dr. Alan Cohan		DEGREE MD		22c. DATE SIGNED 3/2/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Alan Cohan		22e. ADDRESS 13975 Conn. Ave. Silver Spring, Md. 20906			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/7/80		23c. NAME OF CEMETERY OR CREMATORY BOUNTIFUL CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE BOUNTIFUL DAVIS UTAH		24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS			
25a. DATE REC'D. BY REGISTRAR MAR 4 1980		25b. REGISTRAR'S SIGNATURE Robert McCreedy			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 07891									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
LAWRENCE A. KING								3 31 80		3:00 AM	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Male		Caucasian		July 3, 1905		74 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		USA				MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SWEN FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BETHESDA		SUBURBAN		Adm. Ass't.		C.I.A.					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md.		Montg.		Chevy Chase				4740 Bradley Blvd.			
14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)									
(Unknown)		King		Sarah E. Stone							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS							
Yes		WW II		213-46-5234		Margaret Beard Bowie, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary edema terminal										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 weeks	
1629 DUE TO, OR AS A CONSEQUENCE OF (b) Terminal cancer of lung, liver, bladder											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertension, Anemia, Arteriosclerotic Heart Disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from May 26th 1978, to March 31st 1980, that (I) (we) last saw the deceased alive on March 30th 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE S.B. Goswami		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/31/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S.B. GOSWAMI		22e. ADDRESS 5401 Greystone St. Ch. Ch. Md. 20015									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 2, 1980		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN Suitland, Md. COUNTY STATE					
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey		ADDRESS Homes, P.A. Bethesda, Md.		25a. DATE REC'D. BY REGISTRAR APR 7 1980		25b. REGISTRAR'S SIGNATURE					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0 0 7 8 9 2				
1. DECEASED NAME (TYPE OR PRINT)		FIRST IONE		MIDDLE TOWNLEY	LAST KINGSLEY	2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR		
						3/7/80		11:00 AM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR IF UNDER 24 HRS		
Female		White		Mar. 29 1888		91 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Iowa		U.S.A.				Montgomery MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda		4858 Battery Lane				Writer		Writing		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS	
Col.					Denver		YES <input type="checkbox"/> NO <input type="checkbox"/>		1685 Cook St.	
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Robert W. Townley					Jessie Welch					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
No		478-22-8173		Annelise Albert, Dtr., 4858 Battery Lane, Bethesda, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4140								1 Month		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>arteriosclerotic Heart Disease</i>								3 x days		
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)			21f. LOCATION STREET		CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>2/5</i> , 19 <i>80</i> , to <i>3/7</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>2/5</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE			DEGREE			22c. DATE SIGNED				
<i>Joseph P. Segal</i>						3/7/80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							
JACOB P. SEGAL			5530 Wisc. Ave			Chevy Chase Md 20015				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial		3/11/1980		Rockville Cemetery		Rockville, Maryland.				
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons Inc.</i>						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
5130 Wisc. Ave., N.W. Wash., D.C.						MAR 14 1980		<i>Henry H. Brady</i>		

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 only retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 0 0 7 8 9 3			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Ordway Kingston						2a. DATE OF DEATH MONTH DAY YEAR 3/20/80		2b. HOUR 9:55 ^P			
3 SEX male		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR Oct. 4 1899		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) R.I.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10 CITY OR TOWN OF DEATH Bethesda MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Service engineer		12b. KIND OF BUSINESS OR INDUSTRY I.B.M.					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3555 S. Leisure World Blvd. #1-A					
14 FATHER'S NAME FIRST MIDDLE LAST William N. Kingston				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie E. Walls									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-10-0772		17 INFORMANT ADDRESS Mabel Kingston Same as 13e									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5304 CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) WOUND DEHISCENCE, HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (c) RUPTURED ESOPHAGUS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS 2 DAYS 11 DAYS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from OCT 19 75, to 3/20 19 80, that (I) (we) last saw the deceased alive on 3/20 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE Daniel Rosenblum						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/24/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL ROSENBLUM						22e. ADDRESS 10400 CONNECTICUT AV KENSINGTON, MD 20755							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/22/80		23c. NAME OF CEMETERY OR CREMATORY Metropolitan		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Fairfax Va.							
24 FUNERAL DIRECTOR NAME Tyson Wheeler F.H.						ADDRESS 1331 Rockville Pk. Md.		25a. DATE REC'D. BY REGISTRAR MAR 28 1980		25b. REGISTRAR'S SIGNATURE Horton McCreedy			



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THE UNIVERSITY OF CHICAGO

PHYSICS DEPARTMENT

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CHICAGO, ILL.

TO THE PRESIDENT OF THE UNIVERSITY

FROM THE PHYSICS DEPARTMENT

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Medical Examiner called and released
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 0 0 7 8 9 4	
1. DECEASED NAME (TYPE OR PRINT) Dora --- Kirschenbaum			2a. DATE OF DEATH MONTH DAY YEAR MARCH 3 80		2b. HOUR 7:05 AM	
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR Feb. 9, 1894	6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairland Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Hyman --- Nanes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther --- Quint		13e. STREET ADDRESS 1108 Schindler Drive		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Rosalie Epstein, 1108 Schindler, Silver Spring Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> 20 yrs. DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>inst.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 7</u> 19 <u>80</u> to <u>Mar 3</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Feb 16</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Dr. Arthur Bresler</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3-3-80</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Arthur Bresler		22e. ADDRESS 10881 Lockwood Dr., Silver Spring, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/6/80	23c. NAME OF CEMETERY OR CREMATORY New Mt. Carmel Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Glendale, L. Co. New York	
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEM. CHAP., Rockville, Md.		25. DATE REGISTERED MAR 7 1980				
26. REGISTRAR'S SIGNATURE		27. REGISTRAR'S SIGNATURE				

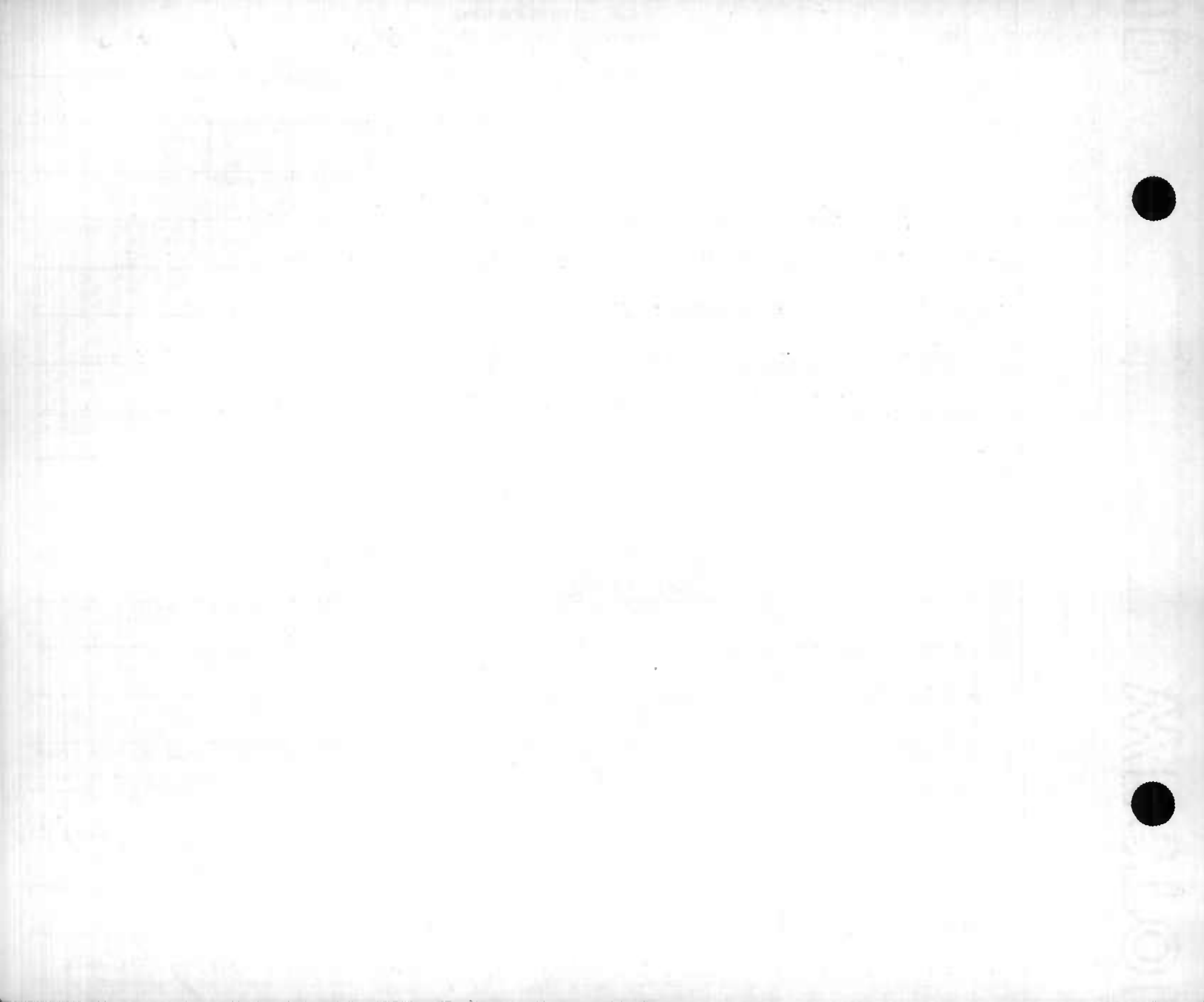
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR			REG. NO. 07895								
1. DECEASED NAME (TYPE OR PRINT)			FIRST Martin			MIDDLE Samuel			LAST Klein		
2a. DATE OF DEATH			MONTH 3			DAY 7			YEAR 80		
3 SEX male			4 RACE white			5. DATE OF BIRTH MONTH 8			DAY 22		
6 AGE (IN YEARS LAST BIRTHDAY) 52			7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery			10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bartender		
12b. KIND OF BUSINESS OR INDUSTRY Hotel			13a. STREET ADDRESS 8204 14th Ave., #101			13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13c. CITY OR TOWN Hyattsville		
14 FATHER'S NAME FIRST Adolph			15 MOTHER'S MAIDEN NAME FIRST Edna			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 1946-1948		
17. INFORMANT ADDRESS Weiner			18. DATE OF OPERATION 3-10-80			19. CONDITION FOR WHICH OPERATION WAS PERFORMED Cheltenham Vet. Cem.			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			22a. SIGNATURE DEGREE 22c. DATE SIGNED		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) V. C. VAID			22c. ADDRESS 7676 New Hampshire Ave #308			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-10-80		
23c. NAME OF CEMETERY OR CREMATORY Cheltenham Vet. Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham, Charles, Maryland			24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEM. CHAP. Rockville, Md.			25a. DATE REC'D. BY REGISTRAR MAR 13 1980		
25b. REGISTRAR'S SIGNATURE Ritney McBrody			26. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u> 4280 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Compensatory Cardiac Failure</u> (c) <u>Azotemia</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Diabetes Mellitus</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			27. DATE SIGNED		



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 0 0 7 8 9 6							
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
Margarette R. KNIGHT				March 27, 1980				2:30 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS	
Female		White		May 17, 1929		50 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Virginia		U.S.A.				Montgomery County, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Damascus		24405 Ridge Rd.				Housewife			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Maryland		Montgomery		Damascus				24405 Ridge Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					
Hobart H. Wolfe		Nora Miller		No					
16a. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> (b) <u>Carcinoma of Colon</u> (c) <u>Due to, or as a consequence of</u>					
579-38-8675		George R. Knight, Item 13		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>over 6 months</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>10-13</u> 19 <u>79</u> to <u>3-27</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>3-27</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
<u>Thomas P. Sloan M.D.</u>				March 27, 1980					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Thomas P. Sloan, M.D.		9701 Church St., Damascus, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		Mar 29, 1980		Mt. View Cemetery		Furdam Montg. Maryland			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. BY REGISTERAR 25b. REGISTERAR'S SIGNATURE					
Molesworth Funeral Home		Damascus, Maryland		APR 2 1980					

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

07897

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Rebecca			FIRST MIDDLE LAST Kolbey			2a. DATE OF DEATH MONTH DAY YEAR March 25 80			2b. HOUR 2:45 P.M.		
3. SEX FEMALE			4. RACE CAUCASIAN			5. DATE OF BIRTH MONTH DAY YEAR SEPT. 8, 1892			6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ROUMANIA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
10. CITY OR TOWN OF DEATH Rockville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HEBREW HOME OF GREATER WASH.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE Maryland			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN KENSINGTON			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH BRAUNSTEIN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA MENDELSON			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 212-64-9280		
17. INFORMANT ADDRESS 3607 Littledale R Kensington, Md.			18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SEPTICEMIA 5990 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) URINARY INFECTION (c) —			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) ACUTE RENAL FAILURE											
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NO			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10/14/71			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3/25/80 to 3/25/80 , that (I) (we) last saw the deceased alive on 3/25/80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE D.D. Patel			DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D.D. PATEL			22e. ADDRESS 6121 MONTROSE ROAD, ROCKVILLE								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3-27-1980			23c. NAME OF CEMETERY OR CREMATORY MT. LEBANON CEM.			23d. LOCATION CITY OR TOWN COUNTY STATE HYATTSVILLE P.G. MD.		
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG CHAPELS			ADDRESS ROCKVILLE MD.			DATE REC'D BY REGISTRAR MAR 31 1980					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Report it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

5/1

10/1

11/1

12/1

1/1

2/1

3/1

4/1

5/1

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7/1

8/1

9/1

10/1

10/1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as any injury, or other traumatic event, the medical examiner must be notified at once.

Released to Attending Physician by Dr. Mayle ME

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 07898	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST REINHARD L. KORGEN					2a. DATE OF DEATH MONTH DAY YEAR March 4, 1980			2b. HOUR 2:11 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 31 1906		6. AGE (IN YEARS LAST BIRTHDAY) 73		7. IF UNDER 1 YEAR MONTHS DAYS YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Program Dir.		12b. KIND OF BUSINESS OR INDUSTRY Nat. Science Foundation			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Hans E. Korgen					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Maria Lunde						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 004-32-1233A		17. INFORMANT ADDRESS Dorothy M. Korgen 4402 Elm. St. CH. CH., Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest 4029 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Dissecting Aneurysm of Aorta Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 min 3 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21e. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from Dec 5 1975 to March 4 1980 , that I (we) last saw the deceased alive on Feb 20 1980 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, I (we) (did) (did not) view the body after death.											
22b. SIGNATURE G. Stuart Scott				DEGREE				22c. DATE SIGNED 3/6/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Stuart Scott				22e. ADDRESS 10401 Old Georgetown Rd. Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Cremation		23b. DATE Mar. 6, 1980		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md;					
24. FUNERAL DIRECTOR NAME JOSEPH GAWLER'S SONS INC.				ADDRESS 5130 WISD. AVE., N. W. WASH., D. C. 20015		25a. DATE REC'D. BY REGISTRAR MAR 10 1980		25b. REGISTRAR'S SIGNATURE Anthony S. Cherry			

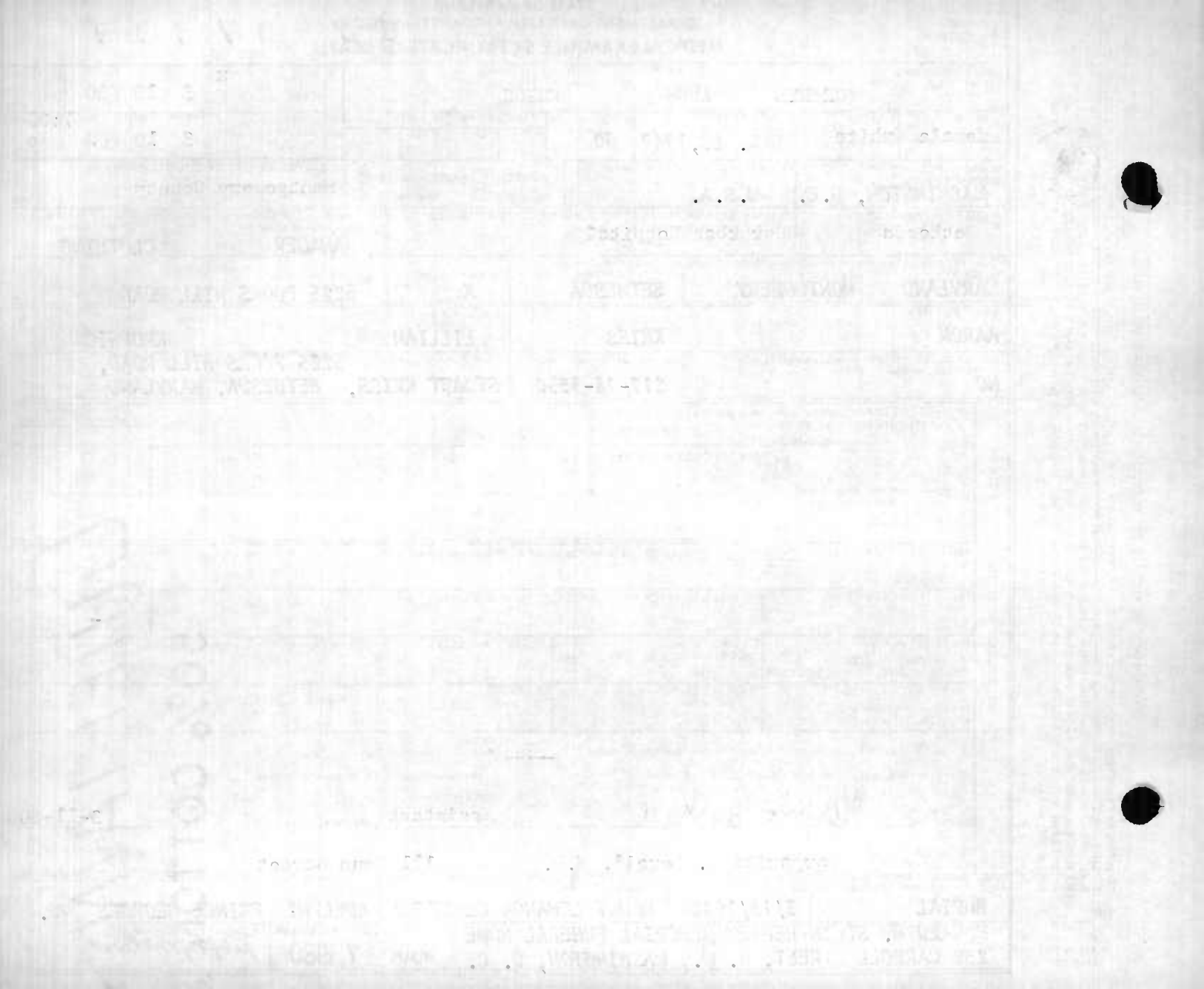
Items 18 & 22a G547 9/4/80 dad

STATE OF MARYLAND

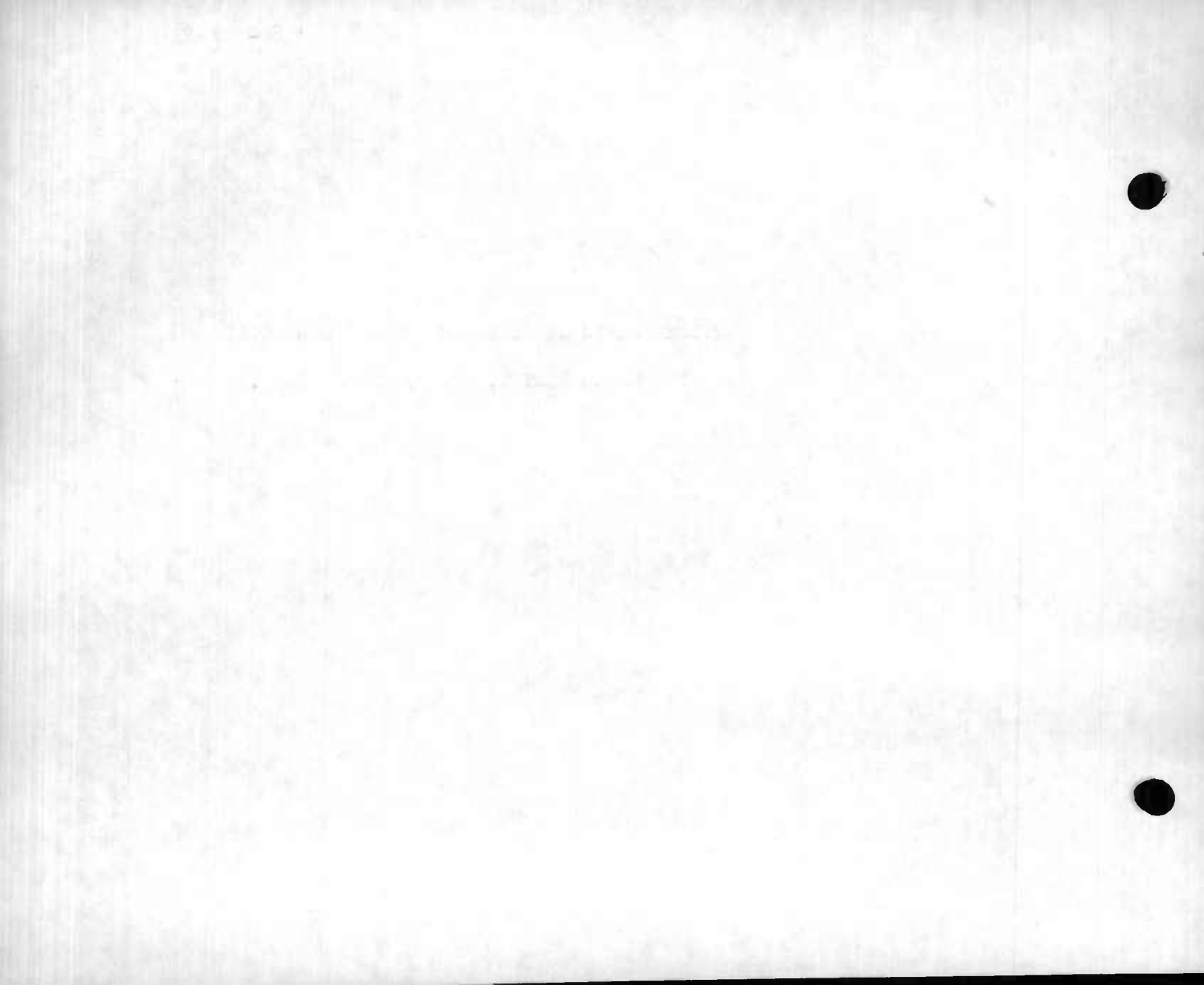
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH07899
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHERYL LYNN KRISS			2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> 3 10 80			2b. HOUR M 10			
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR MAR. 28, 1949	6. AGE (IN YEARS) LAST BIRTHDAY 30	IF UNDER 1 YR. MONTHS DAYS 0 0		IF UNDER 24 HRS. HOURS MIN. 0 0		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 10 80	7d. HOUR a M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County			MD.
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) Suburban Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MANAGER		12b. KIND OF BUSINESS OR INDUSTRY CLOTHING		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5225 POOKS HILL ROAD	
14. FATHER'S NAME FIRST MIDDLE LAST AARON KRISS					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIAN KRUPNIC				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 217-48-3350		17. INFORMANT 5225 POOKS HILL ROAD, STUART KRISS, BETHESDA, MARYLAND				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Undetermined 7999 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE Margie DeKrell			TITLE (SPECIFY) Assistant			DATE SIGNED 3-11-80			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.			ADDRESS 111 Penn Street						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3/13/1980		23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ADELPHI PRINCE GEORGES MD.		
24. DONOR OR FUNERAL HOME NAME ADDRESS DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.					25a. DATE REC'D. BY REGISTRAR MAR 17 1980		25b. REGISTRAR'S SIGNATURE Anthony McCreedy		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 OF VITAL FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH 5 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



VOIDED DEATH CERTIFICATE FILED INCORRECTLY
WITH MARCH DEATHS, NOW FILED IN APRIL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 0 0 7 9 0 1							
1 DECEASED NAME (TYPE OR PRINT) Dorothy H. Lamar					2a DATE OF DEATH MONTH DAY YEAR March 11th, 1980		2b HOUR 5 P M		
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR July 14 1904		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Sumner		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4952 Sentinal Drive				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13b STREET ADDRESS 4952 Sentinal Drive			
13a STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Sumner					
14 FATHER'S NAME FIRST MIDDLE LAST John D. Higgins			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte Crawford						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO 215-46-2043		17 INFORMANT Daughter. ADDRESS Maryland.			17b Dorothy L. Seward 4849 Sangamore Rd Sumner		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4292 Acute Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) 2+ years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 hours									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from July 19 68 to March 11 19 80 , that (I) (we) lost saw the deceased alive on December 10 19 77 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.									
22b SIGNATURE John E. Morris, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 3/12/80			
22d PHYSICIAN'S NAME (TYPE OR PRINT) JOHN E. MORRIS, M.D.				22e ADDRESS 4545 Connecticut Ave, N.W.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 3/15/1980		23c NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland			
24 FUNERAL DIRECTOR Joseph Gawler's Sons Inc.				ADDRESS 5130 Wisc. Ave., N.W. Wash., D.C.		MAR 17 1980			

Dr. John Bell, medical examiner, notified I will examine

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Arwilda F. Lambas			2a. DATE OF DEATH MONTH 3 DAY 12 YEAR 80			2b. HOUR 8:43 A.M.					
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH JUNE DAY 5 YEAR 1905		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 		8. IF UNDER 74 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY NONE		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN POOLESVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 17112 HOSKINSON RD.			
14. FATHER'S NAME FIRST STANLEY MIDDLE LAST FIELD				15. MOTHER'S MAIDEN NAME FIRST LOTTIE MIDDLE LAST HUBBELL							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 578-01-8345D		17. INFORMANT ADDRESS ANNA SIEGERT 14005 BARDOT ST., ROCKVILLE, MD.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 2nd CITY OR TOWN St COUNTY STATE 		21g. DATE SIGNED 3/12/80			
22a. I certify that (I) (this hospital) attended the deceased from 3/11 , 19 80 , to 3/12 , 19 80 , that (I) (we) last saw the deceased alive on 3/11 , 19 80 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. PHYSICIAN'S NAME (TYPE OR PRINT) DR. LEWIS A. DENNIS				22c. ADDRESS 831 UNIVERSITY BLVD., E., SILVER SPRING, MD.				22d. DATE SIGNED 3/12/80			
23a. BURIAL, CREMATION, REMOVAL BURIAL				23b. DATE 3-15-80		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION CITY OR TOWN BRENTWOOD COUNTY P.G. STATE MD.		23e. DATE RECEIVED BY REGISTRAR MAR 20 1980	
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES P/A ADDRESS ROCKVILLE MD.				25. DATE RECEIVED BY REGISTRAR MAR 20 1980							

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

RECEIVED NOTIFICATION

1881

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR		MIN.	
RACHEL						LANIADO		3-31-80								10 ⁵⁵		P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS									
Female		Caucasian		9. MONTH DAY YEAR		77 YRS		MONTHS		DAYS		HOURS		MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Egypt		Unknown				Montgomery													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Bethesda		Suburban Hospital		Never Worked		None													
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS											
Md.		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		1220 East West Highway											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
BeKhor		Laniado		Rena		Picciotto													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		N/A		None		Albert Laniado, 1220 E-W Hgwy., Silver Spring,													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.		IMMEDIATE CAUSE (a)		2500		DUE TO, OR AS A CONSEQUENCE OF		DIABETES MELLITUS		DUE TO, OR AS A CONSEQUENCE OF		25 YRS							
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE									
22a. I certify that (I) (this hospital) attended the deceased from		19 71, to		3-31, 19 80, that (I) (we) last saw the deceased alive on		3-31, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (we) did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED													
Richard H. Pollen M.D.		M.D.		10400 Conn. Ave. Kensington, Md.		4-1-80													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE									
Burial		4-3-80		Mt. Lebanon Cemetery		Hyattsville, P. Geo. Maryland													
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE													
DANZANSKY-GOLDBERG MEM. CHAP.		Rockville, Md.		APR 7 1980		Ruthy McRady													

300-1-1

20

12

CONFIDENTIAL

Page 1

Subject: [illegible]

Date: [illegible]

Location: [illegible]

Time: [illegible]

Weather: [illegible]

Remarks: [illegible]

Signature: [illegible]

Print Name: [illegible]

Rank: [illegible]

Unit: [illegible]

Branch: [illegible]

Service: [illegible]

Assignment: [illegible]

Station: [illegible]

Post Office: [illegible]

City: [illegible]

State: [illegible]

Country: [illegible]

Zip: [illegible]

Phone: [illegible]

Telex: [illegible]

Radio: [illegible]

Mail: [illegible]

Transport: [illegible]

Food: [illegible]

Shelter: [illegible]

Other: [illegible]

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Lake Wales, Florida

Lake Wales Cemetery

Apr. 2

1900

Princox, Va.

Capital Funeral Service

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR THE STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										07905																			
1. DECEASED NAME (TYPE OR PRINT) Blanche M. Leannarda										2a. DATE KNOWN OF DEATH March 5, 1980										2b. HOUR 1:15 A.M.																													
3. SEX F		4. RACE W		5. DATE OF BIRTH AUG. 16, 1989		6. AGE (IN YEARS) 90 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD March 5, 1980										2d. HOUR 1:15 A.M.																											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.																			
10. CITY OR TOWN OF DEATH Takoma Park Wash. D.C.										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. Adventist Hosp.										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife										12b. KIND OF BUSINESS OR INDUSTRY Home																			
13a. STATE Md.										13b. COUNTY P.G. Co.										13c. CITY OR TOWN Adelphi										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS 10410 Glenmore Drive									
14. FATHER'S NAME FIRST Charles MIDDLE A. LAST Mason										15. MOTHER'S MAIDEN NAME FIRST Emma MIDDLE LAST Unknown										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No										16b. SOCIAL SECURITY NO. 577-98-9553										17. INFORMANT Charles Leannarda-10410 Glenmore Dr. Adelphi, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										PART I DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
IMMEDIATE CAUSE (a) 485- Bronchial Pneumonia										DUE TO, OR AS A CONSEQUENCE OF																																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										(b) DUE TO, OR AS A CONSEQUENCE OF																																							
(c)																																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										Fracture Rt Hip																																							
19a. DATE OF OPERATION 2-22-80										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture Rt Hip										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1) OR PART 2 Fell in her room																													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Nursing Home Carroll Ave.										21f. LOCATION STREET Takoma Park CITY OR TOWN Mont COUNTY Md STATE Md																													
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																																							
ACTUAL SIGNATURE John S. Rogers										TITLE (SPECIFY) M.D.										MEDICAL EXAMINER John S. Rogers										DATE SIGNED March 5/80																			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.										ADDRESS 1919 Seminary Rd., Sil. Spr., Md.																																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE Mar. 7, 1980										23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery										23d. LOCATION CITY OR TOWN Suitland COUNTY P.G. STATE Md.																			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi										ADDRESS 11800 N.H. Ave., Sil. Spr. Md.										25a. DATE BY REGISTRAR March 10, 1980										25b. REGISTRAR'S SIGNATURE John S. Rogers																			

RECEIVED
OFFICE OF THE
DIRECTOR
JAN 10 1917

20X TO 100X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

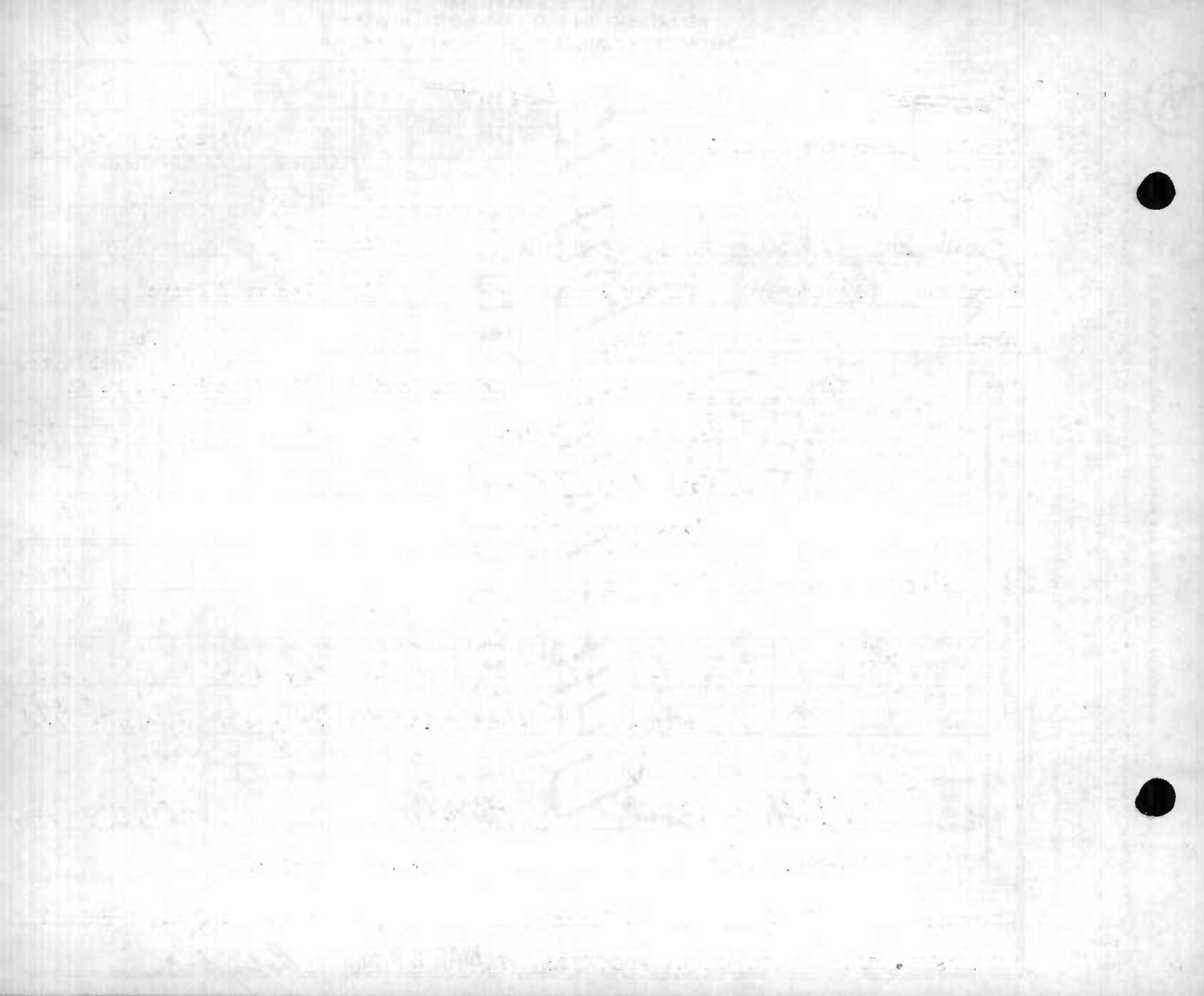
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 0 0 7 9 0 6							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Annie Claudine		HEATHERS						3/19/80 7:00 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR 8. UNDER 24 HRS.	
FEMALE		Caucasian		June 17, 1883		96		YES. HAD AIDS. DAYS. HOURS. MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Virginia		U.S.A.				Montgomery MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							
Olney		Brooke Grove NURSING HOME							
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Housewife		Home							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
Maryland		Montgomery		Silver Spring				15737 New Hampshire	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Thomas Harlow				Alice Davis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				577-01-5988		Henry I. Sweeney Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Sudden Cardiac Death								2	
Coronary Artery Disease								yes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Organic Brain Syndrome									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from 3/18/80 to 3/19/80, that (I) (we) lost saw the deceased alive on 3/18/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
						3/19/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
H. L. [Signature]		18111 Pt Philip Dr. Olney Md 20832							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		Mar. 21 1980		Fairview Cemetery		Culpeper Co., Virginia			
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Capitol Funeral Service, Fairfax, Va.						MAR 24 1980		[Signature]	

BP

FOR 1- STATE REGISTRAR		STATE OF MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH		07907 REG. NO.	
1. DECEASED NAME FIRST MIDDLE LAST <i>Leavitt Mary E</i>		2a. DATE KNOWN OF DEATH MONTH DAY YEAR <i>March 23, 1980</i>		2b. HOUR 12 <i>38</i> AM	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Sept. 13, 1893	6. AGE (IN YEARS) LAST BIRTHDAY 86 YRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>March 23, 1980</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Singer		12b. KIND OF BUSINESS OR INDUSTRY Opera			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME FIRST MIDDLE LAST Abraham ----- Levite		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen ----- Wohl		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. N/A		16c. SOCIAL SECURITY NO. 118-36-9647T		17. INFORMANT Robert Levine, 3501 Rittenhouse, D. C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Contusion & Laceration</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Fracture of Skull-</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Trauma from fall</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <i>Cardiovascular Disease -</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR AM MONTH DAY YEAR P.M. <i>3:21</i> 1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Fall backwards at home -</i>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>11200 Lockwood Dr Silver Spring Mont Md.</i>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>John G. Ball</i>		TITLE (SPECIFY) M.D. <i>Deputy</i>		DATE SIGNED <i>March 23, 1980</i>	
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M. D.		ADDRESS Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3-25-80		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEM. CHAP., ROCKVILLE, MD.		24a. DATE REC'D. BY REGISTRAR MAR 28 1980		24b. REGISTRAR'S SIGNATURE <i>Patricia K. B...</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

80 07908

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Linda B. Lee</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3/4/80</i>		2b. HOUR MIN <i>9:15</i> M	
3. SEX <i>Female</i>		4. RACE <i>Chinese</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Mar. 22, 1926</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>53</i> YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New Jersey</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Systems Consultant</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>N/A</i>
13a. STATE <i>Maryland</i>			13b. COUNTY <i>P.G. Co.</i>	13c. CITY OR TOWN <i>Laurel</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Sing Wah Lee</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Yick Shee</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No.</i>		16b. SOCIAL SECURITY NO. <i>154-22-2287</i>		17. INFORMANT ADDRESS <i>Thomas K. Lee same as #13</i>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <i>1629</i> IMMEDIATE CAUSE (a) <i>Carcinoma of the Lung</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>about 3 years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>1/30</i> , 19 <i>80</i> , to <i>3/4</i> , 19 <i>80</i> , that (I) <input checked="" type="checkbox"/> lost saw the deceased die on <i>3/4</i> , 19 <i>80</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.						
22b. SIGNATURE <i>Joseph B. Mizgerd, MD</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3/5/80</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOSEPH B. MIZGERD, MD</i>			22e. ADDRESS <i>7600 CARROLL AVE, TAKOMA PARK, MD.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3/8/80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cypress Hills Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Brooklyn, New York</i>
24. FUNERAL DIRECTOR <i>FLECK LAUREL FUNERAL HOME, INC.</i> <i>7601 Sandy Spring Rd. Laurel, Md. 20810</i>				25a. DATE REC'D. BY REGISTRAR <i>MAR 7 1980</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

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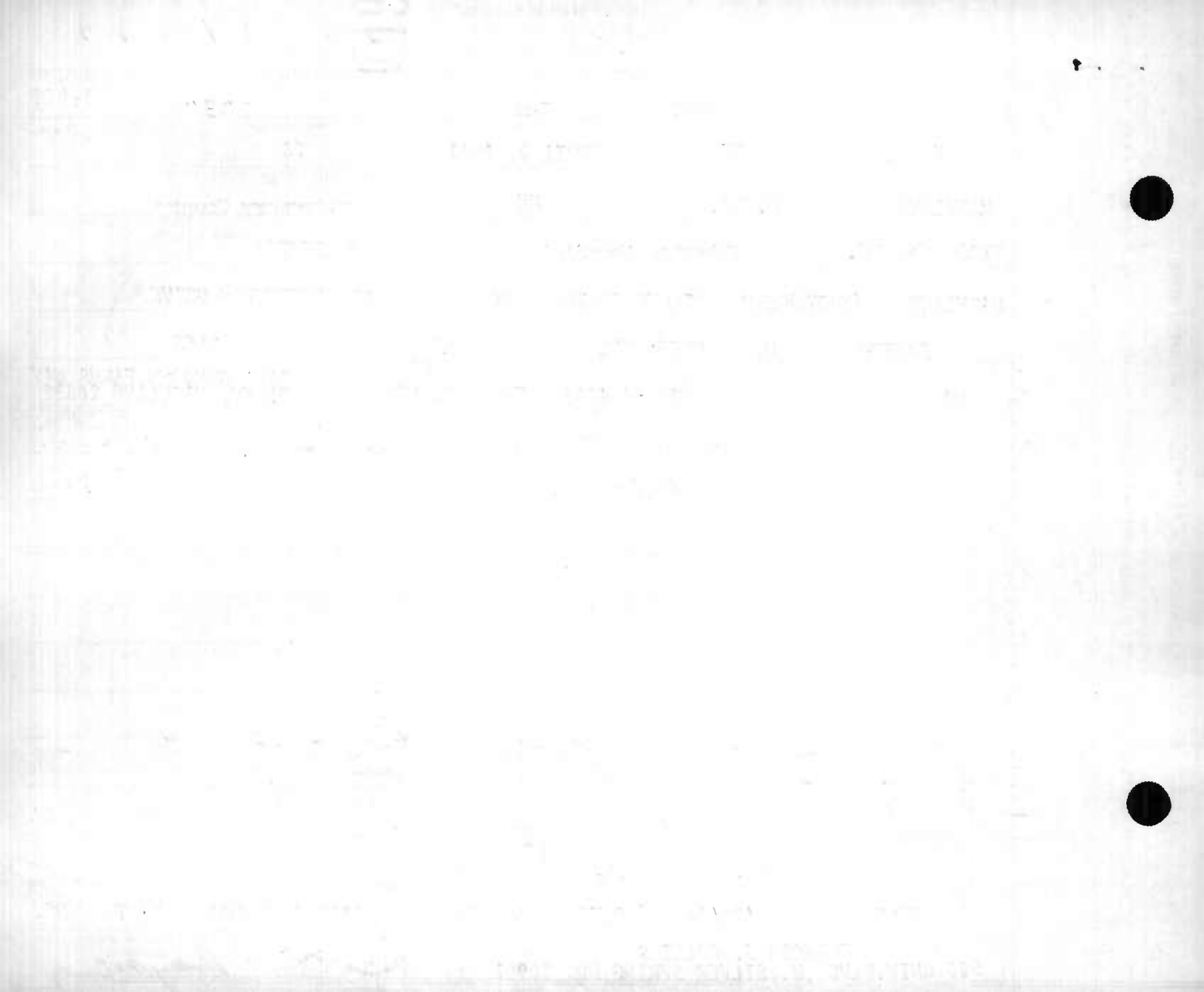
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - Released by Dr. J. F. Foy
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0 0 7 9 0 9			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Violet Teresa Lee				2b. HOUR 12:40P			
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APRIL 9, 1901		6 AGE (IN YEARS LAST BIRTHDAY) YRS. 78	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10 CITY OR TOWN OF DEATH Bethesda, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13c. CITY OR TOWN SILVER SPRING 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 111 LEXINGTON DRIVE			
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH H. GREENWELL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADA JONES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-44-4085		17. INFORMANT SON JAMES H. LEE		ADDRESS 3500 SUNDOWN FARMS WAY OLNEY, MARYLAND 20832	
18. CAUSE OF DEATH (Enter only one cause positive for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): 410 - Sudden Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriosclerotic Heart Disease (c) DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours. 1 1/2 years.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9/26 78		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 9/26 78 3/13 80			
22a. I certify that (1) the hospital attended the deceased from 3/18 80 to 3/13 80 , that (1) was lost saw the deceased alive on 3/18 80 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (1) was (did) not view the body after death.							
22b. SIGNATURE Dr. J. F. Foy				DEGREE MD		22c. DATE SIGNED 3/13/80.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. F. Foy				22e. ADDRESS MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/17/80		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR MAR 17 1981		25b. REGISTRAR'S SIGNATURE Robert McCreedy	
500 UNIV. BLVD., W., SILVER SPRING, MD., 20901							



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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Emilia		Levander		March 15, 80		12:25		A.M.	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		White		MONTH DAY YEAR		79		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Wyoming		USA				Montgomery MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
S.S.		Holy Cross Hospital		Housewife					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS			
Md.		PG		College Pk.		9308 Cherry Hill Rd.			
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT	
Abraham		Liisa		None		331 10 479		9308 Cherry Hill Rd. College Park, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
410 -		Cerebral vascular accident		DUE TO, OR AS A CONSEQUENCE OF		2 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)			
		Acute myocardial infarction							
		Autopsied							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Diabetic mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from March 14, 1980, to March 15, 1980, that (I) (we) last saw the deceased alive on March 14, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
		M.D.				March 15, 1980			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR					
BLAINE H. EIG		2101 Maryland Drive Silver Spring Maryland 20902		MAR 19 1980					
23a. BURIAL, CREMATION, REMOVAL (SEE INSTRUCTIONS)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. STATE	
Cremation		3/18/80		Ft. Lincoln Crematory		Brentwood PG		Md.	
24 FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Hines/Rinski		11800 New Hampshire Ave S.S. Md.				MAR 19 1980			

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1- STATE REGISTRAR					REG. NO. 0007911				
1. DECEASED NAME (TYPE OR PRINT) Charles E. Lewis					2a. DATE OF DEATH MONTH DAY YEAR March 31, 1980			2b. HOUR 12:50 PM	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 25, 1918		6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stone Maker		12b. KIND OF BUSINESS OR INDUSTRY Concrete	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5510 Madison Street	
14 FATHER'S NAME FIRST MIDDLE LAST Alex Lewis					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Hour				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. W.W. II 215-14-6388		17 INFORMANT Birdy O. Lewis		ADDRESS Address Same as No# 13e.			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>metastatic Hodgkin's</i> 1889 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT HOME		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>3/30</i> 19 <i>80</i> to <i>3/31</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>3/30</i> 19 <i>80</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE <i>Lewis H. Dennis</i>					22c. DATE SIGNED 4/1/80			22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis H. Dennis	
22e. ADDRESS 831 Univ. Blvd. E. Silver Spring, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-3-80		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.			
24 FUNERAL DIRECTOR NAME ADDRESS F. Gasch's Sons F.H. P.A. Hyatts. Md.					25a. DATE REC'D. BY REGISTRAR APR 2 1980		25b. REGISTRAR'S SIGNATURE <i>Anthony McCready</i>		

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.		07912					
1. DECEASED NAME (TYPE OR PRINT) MICHAEL EDWARD LEYBA				2. DATE OF DEATH MARCH 13, 1980		2b. HOUR 4:15/1415			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MARCH 13 1980		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		7. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A			
13a. STATE Maryland		13b. CITY OR TOWN P. G. Andrews AFB		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 2132-C Richmond Dr., 20335			
14. FATHER'S NAME MICHAEL NMN LEYBA		15. MOTHER'S MAIDEN NAME LINDA MAE SAWYER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 02-530-50-1098		17. INFORMANT MICHAEL LEYBA 2132 C. RICHMOND DR.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RENAL AGENESIS 7530 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I (this hospital) attended the deceased from 14 MARCH 19 80, to 1945/14 MAR 19 80, that (I) (we) lost saw the deceased alive on 14 MARCH 19 80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE H. T. MCPHEE MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 15 MAR 1980			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUGH T. MCPHEE M.D.				22e. ADDRESS DEPT. OF PEDIATRICS NMMC, BETHESDA, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/19/80		23c. NAME OF CEMETERY OR CREMATORY EMMETT CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE EMMETT, GEM, IDAHO			
24. FUNERAL DIRECTOR NAME W. W. Chambers Co., Silver Spring, Md.				25. DATE RECEIVED BY REGISTRAR 1980		26. REGISTRAR'S SIGNATURE			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE										0 0 7 9 1 3	
1 - STATE REGISTRAR				CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Pete B. Liacuris				2a. DATE OF DEATH MONTH 3/6/80 DAY 18 YEAR 1980				7b. HOUR 9PM			
3 SEX Male		4 RACE white		5 DATE OF BIRTH MONTH 11/7/ DAY 1903 YEAR 1903		6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		8. IF UNDER 1 YEAR MONTHS 77 DAYS 0		9. IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUBURBAN FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner		12b. KIND OF TRADE OR INDUSTRY International			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Potomac				14. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		15. STREET ADDRESS 11705 Castlewood Court					
16. FATHER'S NAME FIRST Basilio MIDDLE Liacuris LAST Liacuris				17. MOTHER'S MAIDEN NAME FIRST Maria MIDDLE Anastasopoulos LAST Anastasopoulos							
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				18b. SOCIAL SECURITY NO. WW 2		19. INFORMANT ADDRESS George Liacuris 4601 N Park Av., Chevy Chase Md					
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Renal Failure DUE TO OR AS A CONSEQUENCE OF (b) prostate Cancer DUE TO OR AS A CONSEQUENCE OF (c) A										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
21. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), (b), OR (c), STATING THE UNDERLYING CAUSE LAST. 185- Acidosis, Acute tubular necrosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Acidosis, Acute tubular necrosis											
22a. DATE OF OPERATION 11/7/80				22b. CONDITION FOR WHICH OPERATION WAS PERFORMED prostate				23a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		23b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
24a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				24b. TIME OF INJURY HOUR A.M. 19 MONTH 11 DAY 7 YEAR 1980 P.M. 19				24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
25a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				25b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				25c. LOCATION STREET Rockledge Dr. #305 Bethesda Md 20834 CITY OR TOWN Bethesda COUNTY Montgomery STATE Md			
26. I certify that (I) (this hospital) attended the deceased from November 7, 1979 to 3/6, 1980 , that (I) (we) last saw the deceased alive on 3/6, 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										27. SIGNATURE Peter Sherer MD DEGREE MD DATE SIGNED 3/7/80	
28a. PHYSICIAN'S NAME (TYPE OR PRINT) PETER B. SHERER MD				28b. ADDRESS 640 Rockledge Dr. #305 Bethesda Md 20834				29. DATE SIGNED 3/7/80			
30a. BURIAL, CREMATION, REMOVAL Burial				30b. DATE Mar 8, 1980				30c. NAME OF CEMETERY OR CREMATORY Parklawn			
31. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Washington, D.C.				32. LOCATION Rockville, Montgomery, Md.				33. DATE SIGNED MAR 11 1980			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										07914 REG. NO.											
1. DECEASED NAME (TYPE OR PRINT) WARREN MERRITT LOCKWOOD SR.										2a. DATE KNOWN OF DEATH March 10 1980										2b. HOUR 5:30 M											
3. SEX Male										4. RACE White										5. DATE OF BIRTH March 1, 1958										6. AGE (IN YEARS) 22 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.										7b. CITIZEN OF WHAT COUNTRY? USA										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mont General Hosp										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Builder Dev.										12b. KIND OF BUSINESS OR INDUSTRY Building	
13a. STATE MD										13b. COUNTY Howard										13c. CITY OR TOWN Woodbine										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME Schee										15. MOTHER'S MAIDEN NAME Jane Cochran										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes										16b. SOCIAL SECURITY NO. W.W. 2 577 28 7967	
17. INFORMANT Warren Lockwood										18. ADDRESS Same as 13										18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF (c) 4291										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None										19a. DATE OF OPERATION None										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										TITLE (SPECIFY) John Rogers										MEDICAL EXAMINER John Rogers										DATE SIGNED March 18, 1980	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation										23b. DATE March 11, 1980										23c. NAME OF CEMETERY OR CREMATORY Lee Funeral Home										23d. LOCATION CITY Wash. COUNTY D. C. STATE	
24. FUNERAL DIRECTOR FRANCIS H. BARBER										25a. DATE REC'D. BY REGISTRAR MAR 14 1980										25b. REGISTRAR'S SIGNATURE John Rogers											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 0 0 7 9 1 5							
1. DECEASED NAME (TYPE OR PRINT) LULA BRIGGS LOGAN					2a. DATE OF DEATH 3/4/80			2b. HOUR 10:50 P M	
3 SEX FEMALE		4 RACE BLACK		5 DATE OF BIRTH 4 13 92		6 AGE (IN YEARS LAST BIRTHDAY) 87		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10 CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson Health Care Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY - 13c. CITY OR TOWN Baltimore					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1802 N. Monroe St		
14 FATHER'S NAME FIRST MIDDLE LAST LONDON WASHINGTON BRIGGS					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ELIZABETH HOLLAND				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-36-1626		17 INFORMANT ADDRESS Asbury Medical Records					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Biventricular pneumonia 485- DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Cerebrovascular insufficiency, chronic brain syndrome									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3/11/76 to 3/4/80, that (I) (we) last saw the deceased alive on 3/28/80, 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Henry C. Scruggs MD				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/5/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HENRY C. SCRUGGS MD				22e. ADDRESS 5413 Cedar Lane Bethesda Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/7/80		23c. NAME OF CEMETERY OR CREMATORY Carver Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Prince Georges Md.			
24. FUNERAL DIRECTOR GARTNER'S SANDISON				25a. DATE REC'D. BY REGISTRAR MAR 10 1980		25b. REGISTRAR'S SIGNATURE [Signature]			

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

07916

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MACIE EUGENIA LOWE			2a. DATE OF DEATH MONTH 3 DAY 24 YEAR 80			2b. HOUR 2 A.M.				
3. SEX Female		4. RACE Cauc		5. DATE OF BIRTH MONTH 8 DAY 21 YEAR 1897		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sharon Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Supply Malory Office &		
13a. STATE MD			13b. COUNTY WASH. D.C.		13c. CITY OR TOWN WASH. D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3133 Connecticut Ave.	
14. FATHER'S NAME FIRST William MIDDLE Henry LAST Henry			15. MOTHER'S MAIDEN NAME FIRST Naenie MIDDLE Derr LAST Derr							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 577-05-3055		17. INFORMANT (Niece) Nancy Walker - 7412 Miller Fall Rd., Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR ARRHYTHMIA DUE TO, OR AS A CONSEQUENCE OF BRONCHY / SCHEMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2 WKS DUE TO, OR AS A CONSEQUENCE OF MYOCARDIAL INFARCTION (c) 2 WKS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: OLD. C.V.A. -										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY BY ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) this hospital attended the deceased from 2/30/80 to 3/24/80 , that (I) (we) last saw the deceased alive on 3/12/80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sign the body after death.										
22b. SIGNATURE D. R. Lewis M.D.			22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 3/24/80		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar. 27, 1980		23c. NAME OF CEMETERY OR CREMATORY Bethel Meth. Ch. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Denver Lincoln N.C.			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi FH ADDRESS 11800 N.H. Ave. Sil. Spr., Md.										

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

BP

MAR 27 1980



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

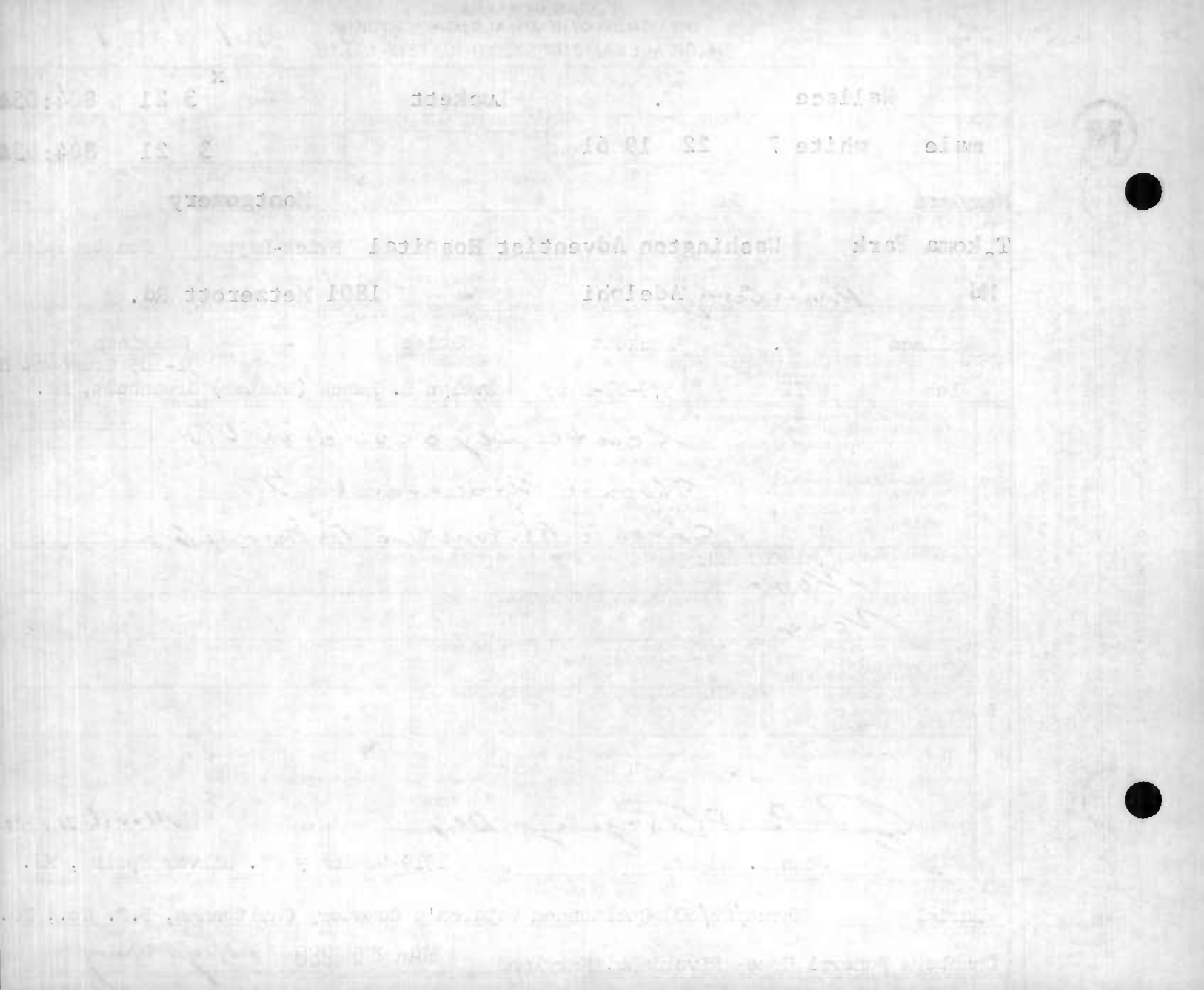
BP
DHMH - 17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07917
REG. NO.

1. FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT) Wallace F. Luckett										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3 21 19 80		2b. HOUR 04:05A	
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 7 22 19 61	6. AGE (IN YEARS) LAST BIRTHDAY YRS. 19 61	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 3 21 19 80	2d. HOUR 04:05A								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.									
10. CITY OR TOWN OF DEATH T. koma Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brick-Layer		12b. KIND OF BUSINESS OR INDUSTRY Construction							
13a. STATE Md				13b. CITY OR TOWN Prince George's Adelphi		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 1801 Metzertott Rd.							
14. FATHER'S NAME FIRST MIDDLE LAST Wallace F. Luckett				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eloise - Mullican											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII		16b. SOCIAL SECURITY NO. 579-09-1465		17. INFORMANT Evelyn E. Beach (Sister)				ADDRESS 51-105 Crescent Rd. Greenbelt, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Pulmonary Dis. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH.															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None															
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) Dep		MEDICAL EXAMINER				DATE SIGNED March 21 1980							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March/26/80		23c. NAME OF CEMETERY OR CREMATORY Cheltonham Veteran's Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Cheltonham, P.G. Co., Md.							
24. FUNERAL DIRECTOR NAME ADDRESS Chambers Funeral Home Riverdale, Maryland				25a. DATE REC'D. BY REGISTRAR MAR 26 1980		25b. REGISTRAR'S SIGNATURE History McBrady									

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 0 0 7 9 1 8						
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR 3-8-80					2b. HOUR 12 ²³ P.M.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary I Lyons					3. SEX Female					4. RACE white	
5. DATE OF BIRTH MONTH DAY YEAR Nov. 13 1899					6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS					7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC					7b. CITIZEN OF WHAT COUNTRY? USA					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD					10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife					11. KIND OF BUSINESS OR INDUSTRY own home	
12. CITY OR TOWN OF DEATH Silver Spring					13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Holy Cross Hospital					14. USUAL RESIDENCE (IF HAVING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Washington, D.C.	
15. FATHER'S NAME FIRST MIDDLE LAST (unknown) Lewis					16. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (unknown)					17. INFORMANT (son) ADDRESS Frank J. Lyons, Jr. - (same as 13e)	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					18b. SOCIAL SECURITY NO 577-84-1378					19. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Entralable Congestive Heart Failure					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs					21. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) disrhythmic C-V disor	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
22a. DATE OF OPERATION 3/4/80					22b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca 7 colon					23a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
24a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					24b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					24c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
25a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					25b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					25c. LOCATION STREET CITY OR TOWN COUNTY STATE	
26. I certify that (I) (this hospital) attended the deceased from 3/7/80 to 3/8/80, that (I) (we) lost saw the deceased alive on 3/7/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
27a. SIGNATURE Martin Eichler					27b. DATE SIGNED 3/8/80					27c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
28a. PHYSICIAN'S NAME (TYPE OR PRINT) Martin Eichler, MD.					28b. ADDRESS 911 Silver Spring, Ave., S.S. Md.						
29a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					29b. DATE 3-11-80					29c. NAME OF CEMETERY OR CREMATORY Arlington National	
29d. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.					29e. ADDRESS 8434 Ga. Ave., S.S. Md.					29f. DATE REC'D BY REGISTRAR 3/19/80	

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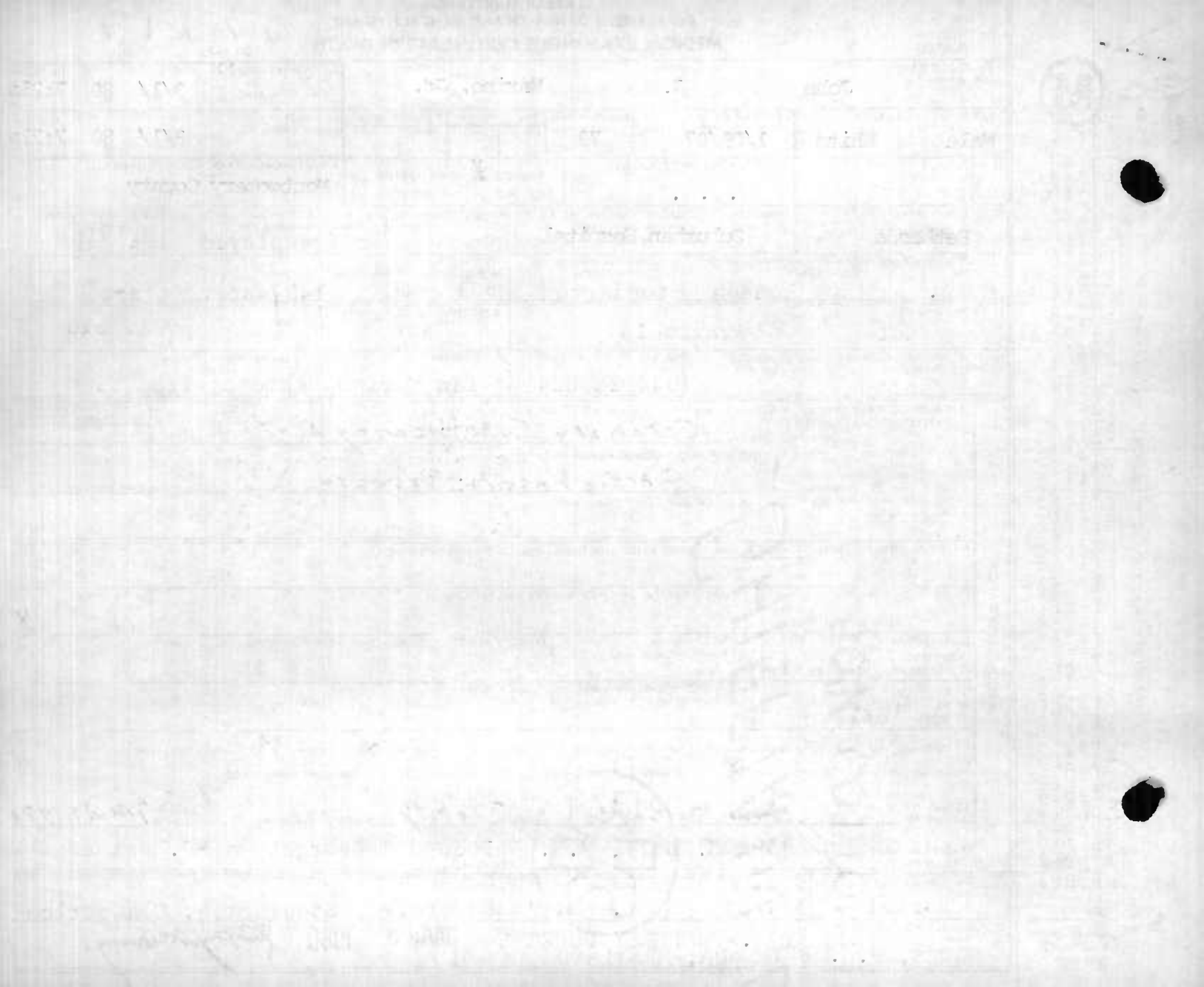
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BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 07919			
1. DECEASED NAME (TYPE OR PRINT) John Joseph Marino										2a. DATE OF DEATH KNOWN OF ESTI-MATED 3/1/80										2b. HOUR 7:21a M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 1/09/07		6. AGE (IN YEARS) 73		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 3/1/80										2d. HOUR 7:21a M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD											
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self employed				12b. KIND OF BUSINESS OR INDUSTRY Driving School							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Conn.										13b. COUNTY New London		13c. CITY OR TOWN Stonington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 149 Water Street							
14. FATHER'S NAME FIRST MIDDLE LAST Not Available					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Available																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 044 28 8241				17. INFORMANT ADDRESS Ida Marino same as item 13															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute.</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Cardio Vascular Disease</u> (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED Mar 1, 1980											
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D.				7936 Old Georgetown Rd. Bethesda Md																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3/4/80		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Stonington, Connecticut													
24. FUNERAL DIRECTOR NAME ROBERT A. HUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND										DATE REC'D. BY REGISTRAR MAR 5 1980						REGISTRAR'S SIGNATURE [Signature]							



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

07920

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Mabel E. Masonis			2a. DATE OF DEATH MONTH DAY YEAR MARCH 29 1980		2b. HOUR 6:15 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 4, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holly Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Bank
13a. STATE Maryland			13b. COUNTY P.G. Co.	13c. CITY OR TOWN Laurel	
14. FATHER'S NAME FIRST MIDDLE LAST Walton R. Freeman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Carmody		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 214-24-3483		17. INFORMANT ADDRESS Frank A. Masonis same as #13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks
179- CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST } DUE TO, OR AS A CONSEQUENCE OF Cancer of Lung - (b) Metastasis from Cancer DUE TO, OR AS A CONSEQUENCE OF in situ (c)		

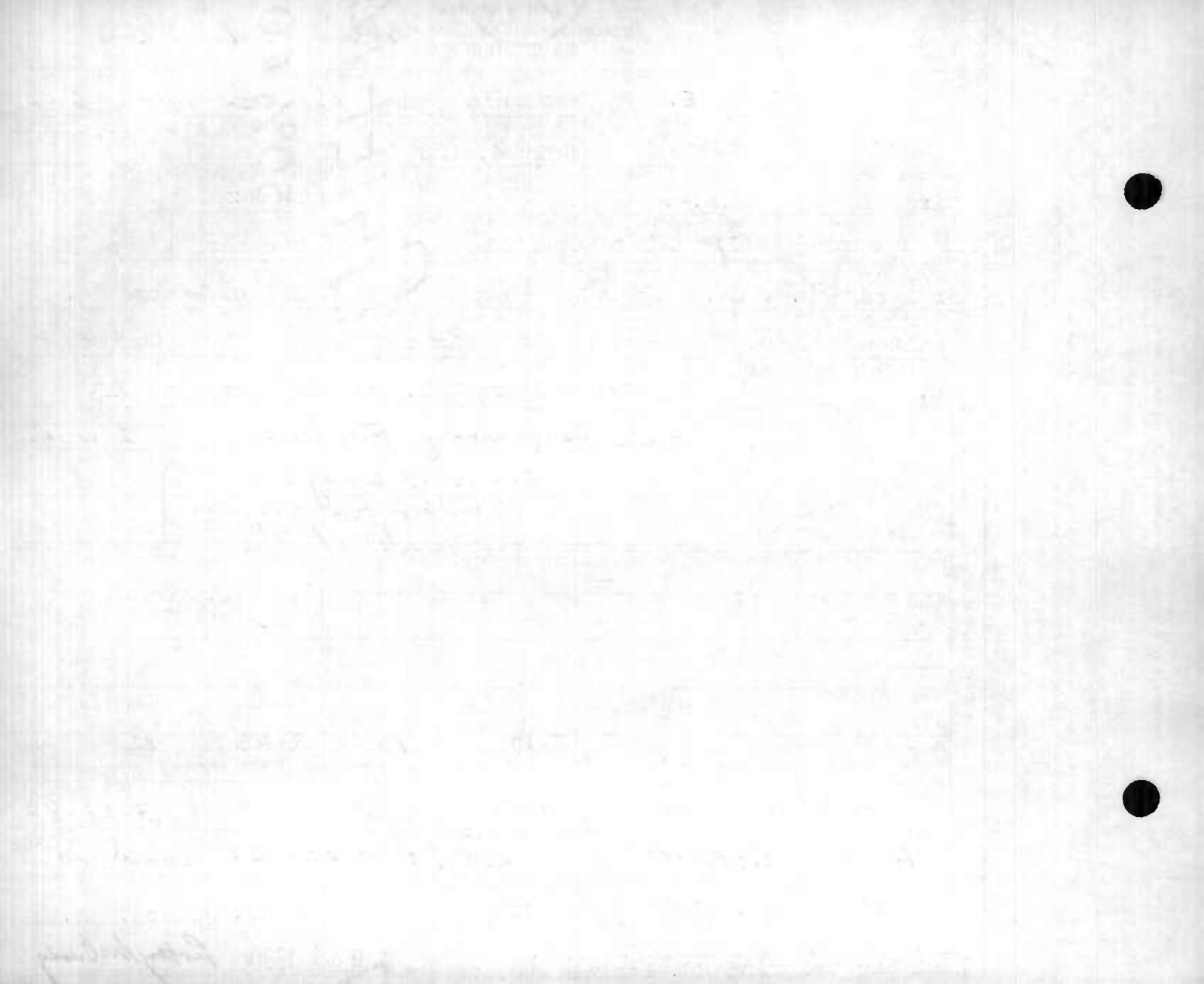
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) -	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) -		21f. LOCATION STREET CITY OR TOWN COUNTY STATE -	
22a. I certify that (I) (this hospital) attended the deceased from 3-17 , 19 80 , to 3-28 , 19 80 , that (I) (we) lost saw the deceased alive on 3-28 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A. Shamim		DEGREE MD		22c. DATE SIGNED 3-29-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AHMAD SHAMIM		22e. ADDRESS 200 FT. MEADE Rd. Laurel, Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/31/80	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park Balto. Howard, Md.	23d. LOCATION CITY OR TOWN COUNTY STATE -
24. FUNERAL DIRECTOR FLECK LAUREL FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel, Md. 20810		25a. DATE REC'D. BY REGISTRAR MAR 31 1980	25b. REGISTRAR'S SIGNATURE Patricia McCurdy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at page 1.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - Cleared & Mailed 3/14/80

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0007921			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Minnie BOWERS Matthews				2a. DATE OF DEATH MONTH DAY YEAR 3 12 80			
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR AUG 8, 1887		6 AGE (IN YEARS LAST BIRTHDAY) 92 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEBRASKA		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10 CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Brooke Grove Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALES LADY		12b KIND OF BUSINESS OR INDUSTRY WOODWARD & LOHMEYER	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN MARYLAND MONTGOMERY CHEVY CHASE				13b INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST MARTIN BOWERS				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CAROLINE CLOUSE			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 577-26-6073		17 INFORMANT ADDRESS ELEANOR M. CONGER SAME AS 13 DAUGHTER			
18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 514- NARCISSISM DUE TO OR AS A CONSEQUENCE OF TERMINAL PULMONARY (Congestion Term) DUE TO OR AS A CONSEQUENCE OF SENILE DEMENTIA				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH WKS YRS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CEREBRAL INFARCTIONS							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE OLNEY MONTGOMERY MD.			
22a I certify that (I) (this hospital) attended the deceased from 3/12/80 to 3/12/80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated				22b SIGNATURE Donald E. Lewis MD		22c DATE SIGNED 3/12/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) D. R. LEWIS MD				22e ADDRESS OLNEY, MARYLAND 20832			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b DATE 3/14/80		23c NAME OF CEMETERY OR CREMATORY FORT LINCOLN CREMATORY		23d LOCATION BRENTWOOD PRI GEO 5th MD.	
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25 DATE REC'D. BY REGISTRAR MAR 1 1980		25b REGISTRAR'S SIGNATURE Anthony McCreedy	
500 UNIV. BLVD. W. SILVER SPRING, MD. 20901							

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U.S.A.

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MONTGOMERY

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2111 FOREVALE STREET

MARTIN

BOOTH

CAROLINE

CLOUSE

NO

577-21-4073

ELWOOD H. COURT

CASE NO. 12


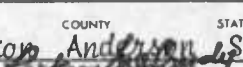
[Faint, mostly illegible handwritten notes and signatures covering the bottom half of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					REG. NO.			
1. FOR STATE REGISTRAR					07922			
1. DECEASED NAME (TYPE OR PRINT) FIRST MAMIE MIDDLE WHITTEN LAST MAYS			2a. DATE OF DEATH MONTH DAY YEAR 3/28/80		2b. HOUR 10 ⁰⁵ AM			
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUG 13 1891		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Employee		12b. KIND OF BUSINESS OR INDUSTRY S.C. School Dep		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Andrew Lewis Whitten			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown Pike					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 251-28-7862		17 INFORMANT daughter Mary M. Martin		ADDRESS same as 13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 438- aspired pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Terminal cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3/5/80 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):								
19a. DATE OF OPERATION 9/9		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE — — — — —				
22a. I certify that (I) (this hospital) attended the deceased from Jan 1980 to 3/28/80 19 —, that (I) (we) last saw the deceased alive on 3/28/80 19 —, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE  no				DEGREE		22c. DATE SIGNED 3/28/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OSOTH LEKAGU MD				22e. ADDRESS 7415 arlington Rd Beltsville Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 31, 1980		23c. NAME OF CEMETERY OR CREMATORY Pendleton United Methodist Church Cemetery		23d. LOCATION (CITY OR TOWN COUNTY STATE) Pendleton Anderson S.C.		
24 FUNERAL DIRECTOR NAME Francis J. Collins				25a. DATE REC'D. BY REGISTRAR APR 3 1980		25b. SIGNATURE 		
500 University Blvd., W. Silver Spring, Md.								

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Francis T. Collins
500 Industrial Bldg.,
Chicago, Ill.
1891

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transcript. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for its burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury or other traumatic event, the medical examiner must be notified.

FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) RICHARD S. McElroy				2a. DATE OF DEATH MONTH DAY YEAR MARCH 18 1980				2b. HOUR 0255A			
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR January 15, 1888		6 AGE (IN YEARS LAST BIRTHDAY) 92		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN YRS.		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Warehousing			
13a. STATE MARYLAND				13b. COUNTY Montgomery		13c. CITY OR TOWN Darnestown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 15617 Bondy Lane	
14 FATHER'S NAME FIRST MIDDLE LAST Richard McElroy				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte McNeil							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO 152037492		17 INFORMANT ADDRESS John B. McElroy, Same as 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia 4871 DUE TO, OR AS A CONSEQUENCE OF (b) influenza Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) senility										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 2 DAYS YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION, GIVEN IN PART 1 (a) CONGESTIVE HEART FAILURE											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 3/18/80 to 3/18/80 , that (I) (we) lost saw the deceased alive on 3/18/80 above, (the hospital) (did not) view the body after death. (my opinion) (my opinion) death occurred on the date and hour and from the causes stated											
22b. SIGNATURE Thos G. Ward DECEASED ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22c. DATE SIGNED 3/18/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. Ward										22e. ADDRESS 6116 Robinwood, Bethesda, MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3-20-80		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Bronx, New York			
24 FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY						24b. ADDRESS FUNERAL HOMES, P. A., Rockville, Maryland		25a. DATE REC'D. BY REGISTRAR MAR 24 1980		25b. REGISTRAR'S SIGNATURE W. J. McElroy	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07924
REG. NO.

FOR 1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Helen</i>	MIDDLE <i>Wills</i>	LAST <i>McGee</i>	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR		2b. HOUR M
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>May 8, 1912</i>	6. AGE (IN YEARS) LAST BIRTHDAY) <i>67</i> YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD <i>3/25 1980</i>		2d. HOUR M <i>4:40</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Frederick, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County</i> MD.			
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>3535 Briggs Chaney Road</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>House Wife.</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>3535 Briggs Chaney Road</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Millard C. Wiles.</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No.</i>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Andrew M. McGee (Husband)</i>				13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. <i>hypertensive heart disease.</i> (b) <i>hypertensive heart disease.</i> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Years</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Generalized viral infection.</i>									
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>None</i>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>John S. Rogers, M.D.</i>		EXAMINER'S NAME (TYPE OR PRINT) <i>John S. Rogers, M.D.</i>		TITLE (SPECIFY) <i>Deputy</i>		MEDICAL EXAMINER <i>1919 Seminary Road Silver Spring, Montgomery, Md.</i>		DATE SIGNED <i>3/25/80</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Mar. 28, 1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park,</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Md.</i>			
24. FUNERAL DIRECTOR NAME <i>J. Arthur Walters.</i>				25a. DATE REC'D. BY REGISTRAR <i>MAR 28 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Dorothy McCready</i>			

71

Helena

Willa

Lucas

x

Female White Top 8, 1912 07

x

Frederick, W. B. E. 1.

Anderson, C. W.

Silver Spring 3537 (C. W. Anderson)

Home 1910.

Anderson, C. W. 3537 (C. W. Anderson)

William C. Wicks.

Ho.

Anderson, W. B. (Anderson) 1910

acute myocardial disease

hypertensive heart disease

Yama

General viral infection

None

x

none

x

x

3538

Willa

1910 (Anderson)

Anderson, C. W. 3537 (C. W. Anderson)

Willa, W. B.

Anderson, W. B. 1910 (Anderson) 1910

Anderson, W. B. 1910 (Anderson) 1910

Anderson, W. B. 1910 (Anderson) 1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 07925			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 3-20-80			
1. DECEASED NAME (TYPE OR PRINT) Anna Frances McGovern				2b. HOUR 7:45 P.M.			
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 29 1901		6. AGE (IN YEARS LAST BIRTHDAY) 78	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Washington Adventist		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Telephone Oper		12b. KIND OF BUSINESS OR INDUSTRY Capitol Hill	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Pr Geo 13c. CITY OR TOWN Temple Hills				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Patrick McGovern				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Dolan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. ---		17. INFORMANT Ann D. Miller		ADDRESS Same as #13	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Severe Malnutrition, Senility, Arteriosclerosis, Heart Disease.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/12 19 80, to 3/20 19 80, that (I) (we) last saw the deceased alive on 3/20 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Antonio G. Uy				DEGREE MD		22c. DATE SIGNED 3/21/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANTONIO G. UY MD				22e. ADDRESS 831 Union Blvd. E. Md 20903			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 24Mar1980		23c. NAME OF CEMETERY OR CREMATION Resurrection Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton PG Md.	
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm				25a. DATE REC'D. BY REGISTRAR 28 MAR 1980			
F Funeral Home Inc				S Suitland, Md.			

100% COTTON FIBER

MADE IN U.S.A.



MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Released by John S. Rogers - Montgomery County Medical Examiner

MEDICAL CERTIFICATION

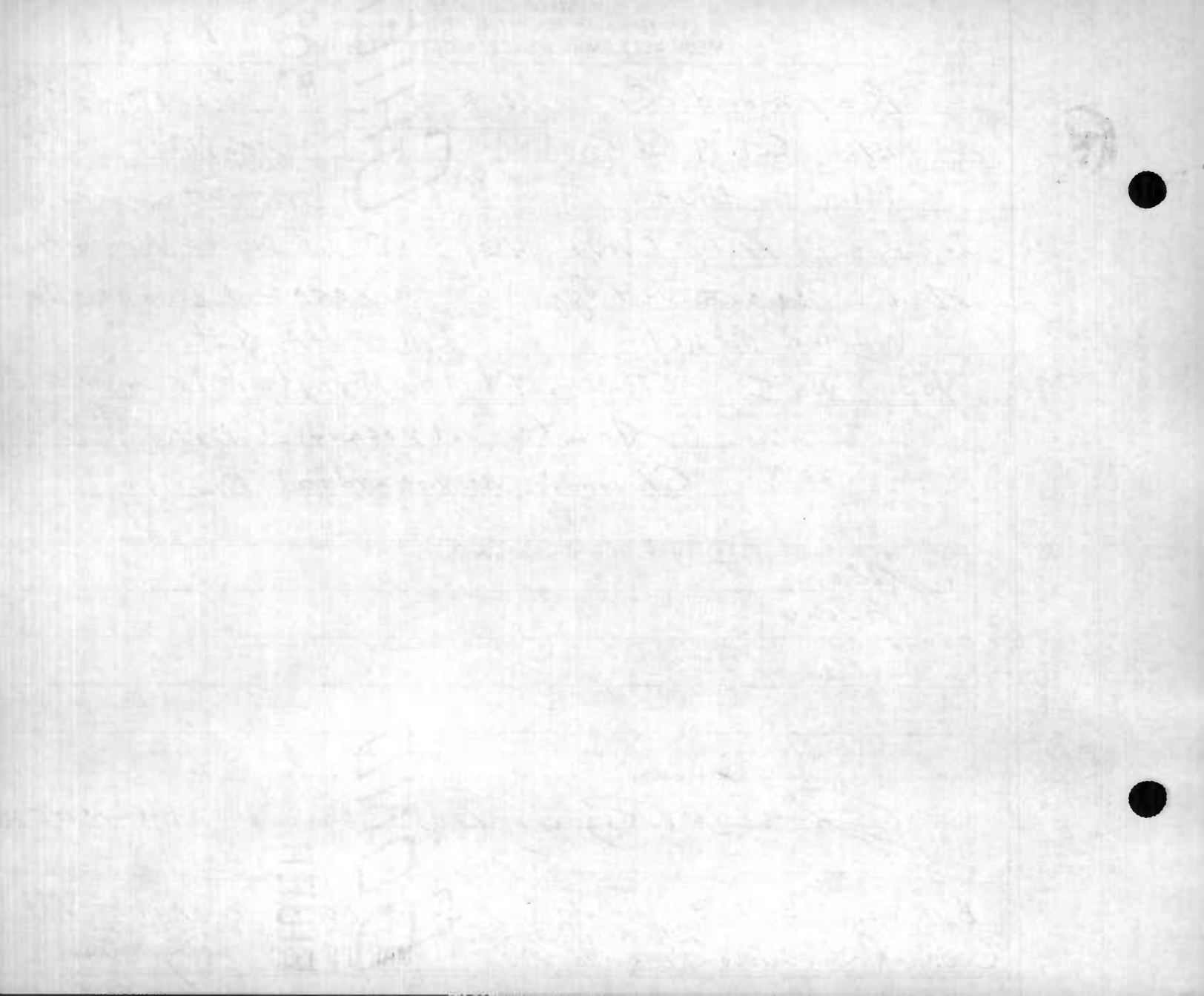
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.		0 0 7 7 2 6					
1 DECEASED NAME (TYPE OR PRINT)		FIRST WILLIAM MIDDLE PARKE LAST McHENRY, Sr.		2a. DATE OF DEATH		MONTH DAY YEAR		7b. HOUR	
William P		McHenry, Sr.		3 2 80		11:58 PM			
3 SEX		4 RACE		5 DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Male		White		Feb. 3 1905		75 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
West Virginia		U.S.A.				Montgomery MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Holy Cross Hospital		Accountant (Ret)		Real Estate			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		No		577-10-1575		Valerie C McHenry, Wife. Same as item 13.	
Amos Musser McHenry		Mary Ellen Parke							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		410- Cardiac arrest		DUE TO, OR AS A CONSEQUENCE OF (b)		Cardiogenic shock		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost				DUE TO, OR AS A CONSEQUENCE OF (c)		acute myocardial infarction		36 min	
								24 hours	
								36 hours	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3/2 19 80, to 3/2 19 80, that (I) (we) lost saw the deceased alive on 3/2 19 80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
Mark Rosen MD						3/2/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR					
Mark Rosen, M.D.		1131 West University Blvd. Wheaton, Md.		MAR 7 1980					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
Burial		3/7/1980		Cedar Hill Cemetery		Suitland, Md.		COUNTY STATE	
24 FUNERAL DIRECTOR		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Joseph Gawler's Sons Inc.		5130 Wisc. Ave., N.W. Wash., D.C.		MAR 7 1980		[Signature]			

Joseph's Sons Inc.
1000

1111 and University Ave., Madison, Wis.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										07927 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Raymond C. McRoy										2a. DATE KNOWN OF DEATH MONTH DAY YEAR March 15 1980	
3. SEX M	4. RACE BLK	5. DATE OF BIRTH MONTH DAY YEAR Oct. 19, 1926	6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR March 15 1980		2b. DATE OF ESTI. MATED MONTH DAY YEAR March 15 1980		2d. HOUR 5 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery					
10. CITY OR TOWN OF DEATH D.C. Spg.		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY State Rd. Comm.			
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN D.C. Spg.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 10502 S. Dunmore Dr.			
14. FATHER'S NAME FIRST MIDDLE LAST Walter McRoy				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Hackett							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 579-30-7619		17. INFORMANT Virginia McRoy (wife)		17. ADDRESS SAME AS #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. Chronic Myocardial Infarction (b) Chronic Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE George R. Snowden				TITLE (SPECIFY) M.D.				MEDICAL EXAMINER		DATE SIGNED March 15 1980	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-19-80		23c. NAME OF CEMETERY OR CREMATORY Lincoln Park Cem.				23d. LOCATION CITY OR TOWN Rockville		COUNTY Montg	
24. FUNERAL DIRECTOR NAME George R. Snowden		ADDRESS 246 N. Wash. St., Rockville, Md.		25a. DATE REC'D. BY REGISTRAR MAR 19 1980		25b. REGISTRAR'S SIGNATURE Henry McCreedy					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-5947.

Cleared by Dr. Mayle M.E.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0 0 7 9 2 8			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) Nicolas F. Mendoza				2a. DATE OF DEATH March 2, 1980		2b. HOUR 12:30P	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH Sept. 10, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cuba		7b. CITIZEN OF WHAT COUNTRY? Cuba		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Bethesda Health Care Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OR WORKING LIFE) Lab Technician		12b. KIND OF BUSINESS OR INDUSTRY Microbiology	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland Montgomery Silver Spring				13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 1903 East West Highway	
14. FATHER'S NAME Cristobal Mendoza		15. MOTHER'S MAIDEN NAME Tomas Fernandez		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16a. SOCIAL SECURITY NO. 220-54-0536		17. INFORMANT Walter Mendoza		17a. ADDRESS 8711 Rayburn Road Bethesda, Maryland 20034			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal cerebral thrombosis						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years	
438- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) — DUE TO, OR AS A CONSEQUENCE OF (c) —							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): —							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY 3/20/1979 HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION — STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/20/1979 19 March 20, 1980 19 March 20, 1980 that (I) (we) lost saw the deceased alive on 3/20/80 19 March 20, 1980 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/2/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OSOTH LEKAGUL, MD		22e. ADDRESS 7425 arlington Rd Bethesda Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/4/80		23c. NAME OF CEMETERY OR CREMATORY St. Gabriel's Cem		23d. LOCATION Potomac, Maryland CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR A. Pumphrey		24a. ADDRESS 7557 Wisconsin Ave., Bethesda, MD		25. DATE REC'D. BY REGISTRAR MAR 10 1980		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
1. FOR STATE REGISTRAR			REG. NO. 07929												
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR				
Ray			Michael			03			10 30			25 AM			
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			# UNDER 1 YEAR MONTHS DAYS		# UNDER 24 HRS HOURS MIN.	
7			Caucasian			Oct. 18, 1889			90						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH						
New York			USA						MONTGOMERY COUNTY MD.						
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring			Holt Cross Hospital						Homemaker			Home			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
Maryland			Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6314 Tone Drive						
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME												
FIRST MIDDLE LAST			FIRST MIDDLE LAST												
Julius			Becker			Celia			Krieger						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17 INFORMANT ADDRESS									
No			061-28-8709			Harriette Baker, 6314 Tone, Bethesda, Md.									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) UREMIA										1 MO					
4409 DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															
(b) ARTERIOSCLEROTIC VASCULAR DISEASE															
DUE TO, OR AS A CONSEQUENCE OF															
(c) AND PULMONARY EMBOLISM										1 MO					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) () () attended the deceased from 9 FEB 19 80 to 10 MAR 19 80, that (I) () lost saw the deceased alive on 9 MAR 19 80, and that in (my) () opinion death occurred on the date and hour and from the causes stated above, (I) () () (did not) view the body after death.															
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED						
Walter Goozh, M. D.									10 MAR 80						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS												
Walter Goozh, M. D.			2309 Shorefield Rd., Rockville, Maryland												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial			2-12-80		King David Mem. Gdn.			Falls Church, Virginia							
24 FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
DANZANSKY-GOLDBERG MEM. CHAP.,			Rockville, Md.			MAR 17 1980			Walter Goozh						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST		3-25-80		6:15 P.M.	
Charlotte F. MILLER					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	
Female	White	August 25 1888	91 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
D.C.	U.D.S.		Montgomery MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda	Fernwood House	Clerk	U.S. Gov't.		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS
D.C.		Washington			1417 Kalmia Rd. N.W.
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
William Miller		Mary Heine			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
No		578-62-0217	Sister Wash., D.C.		
			Margaret E. Reisinger 1417 Kalmia Rd N.W.		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
485- Broncho pneumonia					3 weeks.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF (b)					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from October 16 1979 to March 25 1980, that (I) (we) lost saw the deceased alive on March 12 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Blaine Fitzgerald, M.D.		MD		3/25/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Blaine Fitzgerald, M.D.		8218 Wisc. Ave. Bethesda, Md. 20014			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Mar. 29, 1980	Rock Creek Cemetery	Washington, D.C.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Joseph Gawler's Sons Inc. 5130 Wisconsin Ave., N.W. Washington, D.C.		APR 7 1980		619	



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 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

07931

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
M		Josephine		MILLER				Mar.		17		19		80		749		A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Female		Cauc.		June 27 1922		57 YRS.						Mar.		17		19		80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH							
England		U.S.A.										Montgomery							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Bethesda		National Naval Medical Center		Travel Agent		Travel Agency													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Maryland		Montgomery		Chevy Chase		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4304 Rosemary Street											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
James		F.		Gibson		Mary		Cullen											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		213 14 8887		Lincoln T. Miller		See item 13													

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) -fatty Fatty metamorphosis of the liver acute
 DUE TO, OR AS A CONSEQUENCE OF
 (b) Chronic alcoholism
 DUE TO, OR AS A CONSEQUENCE OF
 (c) _____

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

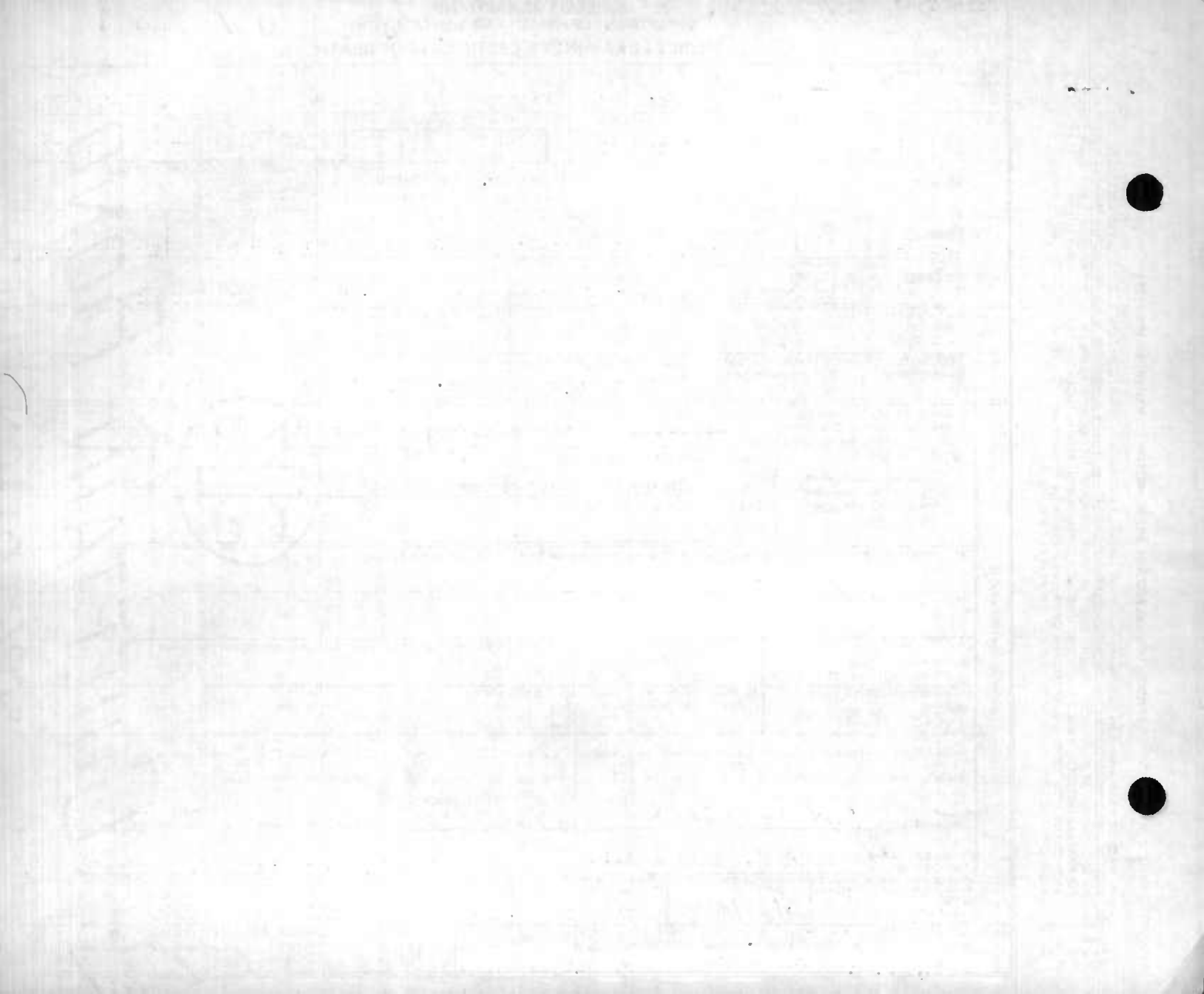
22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE John G. Ball TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 17 Mar. 1980

EXAMINER'S NAME (TYPE OR PRINT) JOHN G. BALL, M.D. ADDRESS 7936 Old Georgetown Rd. Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE (SPECIFY)		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		3/21/80		Arlington National		Arlington Arlington Va.	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
HOMES, P.A. BETHESDA, MARYLAND				MAR 21 1980		<u>Anthony M. Crady</u>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					REG. NO. 07932				
1. DECEASED NAME (TYPE OR PRINT) ALICE LOUISE MILLS					2b. DATE OF DEATH MONTH DAY YEAR 3-5-80				
3 SEX Female					4 RACE white				
5. DATE OF BIRTH MONTH DAY YEAR 8-21-89					6. AGE (IN YEARS LAST BIRTHDAY) 90				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Conn.					7b. CITIZEN OF WHAT COUNTRY? U. S. A.				
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10 CITY OR TOWN OF DEATH Bethesda					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hosp.				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife					12b. KIND OF BUSINESS OR INDUSTRY own home				
13a. STATE Maryland					13b. COUNTY Montgomery				
13c. CITY OR TOWN Bethesda					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13e. STREET ADDRESS 10619 Weymouth Street									
14 FATHER'S NAME FIRST MIDDLE LAST George Weston					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Grady				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					16b. SOCIAL SECURITY NO. 034-09-9160 D				
17 INFORMANT Francis Mills					ADDRESS 10619 Weymouth St., Beth. Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 weeks	
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular								years	
(c) Disease									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Recurrent Sarcoma Lt. Arm. Diabetes mellitus									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19				
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from April 19 78 , to March 5 19 80 , that (I) (we) last saw the deceased alive on March 4 19 80 , and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Delwitt E. DeLauter M.D.					22c. DATE SIGNED Mar 5, 80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Delwitt E. DeLauter M.D.					22e. ADDRESS 5500 Friendship Blvd. Chevy Chase Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation					23b. DATE Mar. 5, 1980				
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory					23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Prince Geo., Md.				
24 FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.					25. FILED RECEIVED BY REGISTRAR 75 REG. NO. 75 MAR 10 1980				
5130 Wisconsin Ave., N. W., Washington, D. C.									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Blanche F. MINOVICH					2a. DATE OF DEATH MONTH DAY YEAR March 16, 1980			2b. HOUR 5:30P M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 31, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Conn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Adm. Officer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3410 Hewitt Ave., Apt. 204	
14. FATHER'S NAME FIRST MIDDLE LAST James Irving Fraser					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie M. Wolfe					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 041-14-2848		17. INFORMANT ADDRESS Christopher J. Minovich, Item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Glioblastoma 1919 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION 1977 & 1979			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Glioblastoma			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 2-1 , 19 80 , to 3-16 , 19 80 , that (we) lost saw the deceased alive on 2-13 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (which) (did not) view the body after death.										
22b. SIGNATURE James W. Egan M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-17-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James W. Egan, M.D.			22e. ADDRESS 5413 Cedar Lane, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar. 19, 1980		23c. NAME OF CEMETERY OR CREMATORY Forest Oak		23d. LOCATION CITY OR TOWN COUNTY STATE Gaithersburg, Montg., Md.			
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, Damascus, Md.					25a. DATE REC'D. BY REGISTRAR MAR 19 1980		25b. REGISTRAR'S SIGNATURE Anthony McCready			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 0 0 7 9 3 4							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John — Missakian						2a. DATE OF DEATH MONTH DAY YEAR 3-23-80		2b. HOUR 5:19 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 15 1903		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Turkey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Produce Clerk		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY P.G. 13c. CITY OR TOWN Suitland 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>						13e. STREET ADDRESS 3519 Parkway Terrace Dr.			
14. FATHER'S NAME FIRST MIDDLE LAST Richard Missakian						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Karibian			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 227-14-9553		17. INFORMANT ADDRESS Same as Above Alma Louise Missakian, Wife,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory failure</u> 1629 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>spontaneous lung cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1) OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from 3/13, 1980, to 3/20, 1980, that (he) (we) last saw the deceased alive on 3/20, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (If we did not view the body, after death, so state.)									
22b. SIGNATURE <i>Lewis H. Dennis</i>						DECLARATION ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/20/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis H. Dennis						22e. ADDRESS 831 Univ. Blvd. E., Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-26-80		23c. NAME OF CEMETERY OR CREMATORY W. Hampton Mem. Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Richmond, Virginia			
24. FUNERAL DIRECTOR NAME Robt E Wilhelm						ADDRESS 4308 Suitland Rd., Suitland, Md.		25. DATE REC'D. BY REGISTRAR MAR 28 1980	

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0 0 7 9 3 5			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR			
Lillian M Momyer				3-10-80 6:00PM			
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)	
FEMALE		WHITE		SEPT 1, 1909		70 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		U.S.A.				MONTGOMERY	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
SILVER SPRING		HOLY CROSS HOSPITAL		HOMEMAKER			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13e. STREET ADDRESS	
MARYLAND		MONTGOMERY		SILVER SPRING		1003 LAREDO ROAD	
14 FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
JOHN RUSSELL				CORA BURRISS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17 INFORMANT ADDRESS			
NO		213-66-1977		JAMES S. MOMYER, SR. SAME AS 13 HUSBAND			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) 1913 Cardiac pulmonary Arrest							
DUE TO, OR AS A CONSEQUENCE OF (b) Left Parietal Glioblastoma Multiforme							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
3 JAN 1980		Left Parietal Glioblastoma Multiforme		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 12/26/79 to 3/10/80, that (I) (we) lost saw the deceased alive on 3/10/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
FREDERIC T. SCHWARTZMAN						10 March 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
FREDERIC T. SCHWARTZMAN				5454 Wisconsin Ave. Chevy Chase			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		3/14/80		MT. CARMEL CEMETERY		SUNSHINE MONT MD.	
24 FUNERAL DIRECTOR NAME				25a. DIED AT HOME BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
FRANCIS J. COLLINS				MAR 1 1980			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR			
HAROLD C MOORE				3-2-1980 6:05 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE		C		Oct. 25 '30		49 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Michigan		U.S.A.				Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rockville		SHADY GROVE ADVENTIST HOSPITAL		Machinist			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Montgomery		Germantown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Albert - Moore				Dorothy - Allene Md.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		064-24-1882		Patricia M. Moore		19148 Aldenham Ct. Germantown, Md.	
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Cardio-pulmonary arrest							3 min
1629 DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
b) Bronchogenic Carcinoma							8 mo ⊕
DUE TO, OR AS A CONSEQUENCE OF							
c) —							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
Pneumonitis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Oct 8, 1979, to March 2, 1980, that (I) (we) last saw the deceased alive on March 1, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
James R. Moore, Jr.				MD		3-2-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
James R. Moore, Jr.				207 Brookes Ave Gaithersburg Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Mar. 5, '80		Forest Oak Cemetery		Gaithersburg Montg. Md.	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Gartner-Sandison F. H. Gaithersburg, Md.				MAR 5 1980		[Signature]	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 07937	
1. DECEASED NAME (TYPE OR PRINT) Romey Elijah Moore										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 3/21 1980	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 30, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2b. DATE PRONOUNCED DEAD 3/21 1980	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10921 Inwood Avenue, #333				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction Worker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10921 Inwood Avenue, #333			
14. FATHER'S NAME FIRST MIDDLE LAST James L. Moore				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella H. Harris							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Unknown				16b. SOCIAL SECURITY NO. 242-05-3536		17. INFORMANT Sister Emma M. Tucker		ADDRESS Roanoke Rapids, N. C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 4291 (b) chronic myocardial disease DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Diabetes mellitus											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE [Signature]				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER		DATE SIGNED 3/21/80	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Mar. 24, 1980		23c. NAME OF CEMETERY OR CREMATORY Sunset Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Littleton Halifax N. C.			
24. FUNERAL DIRECTOR NAME Francis J. Collins						25a. DATE REC'D. BY REGISTRAR MAR 26 1980		25b. REGISTRAR'S SIGNATURE [Signature]			
26. FUNERAL HOME ADDRESS 400 University Blvd., West Silver Spring, Md.											

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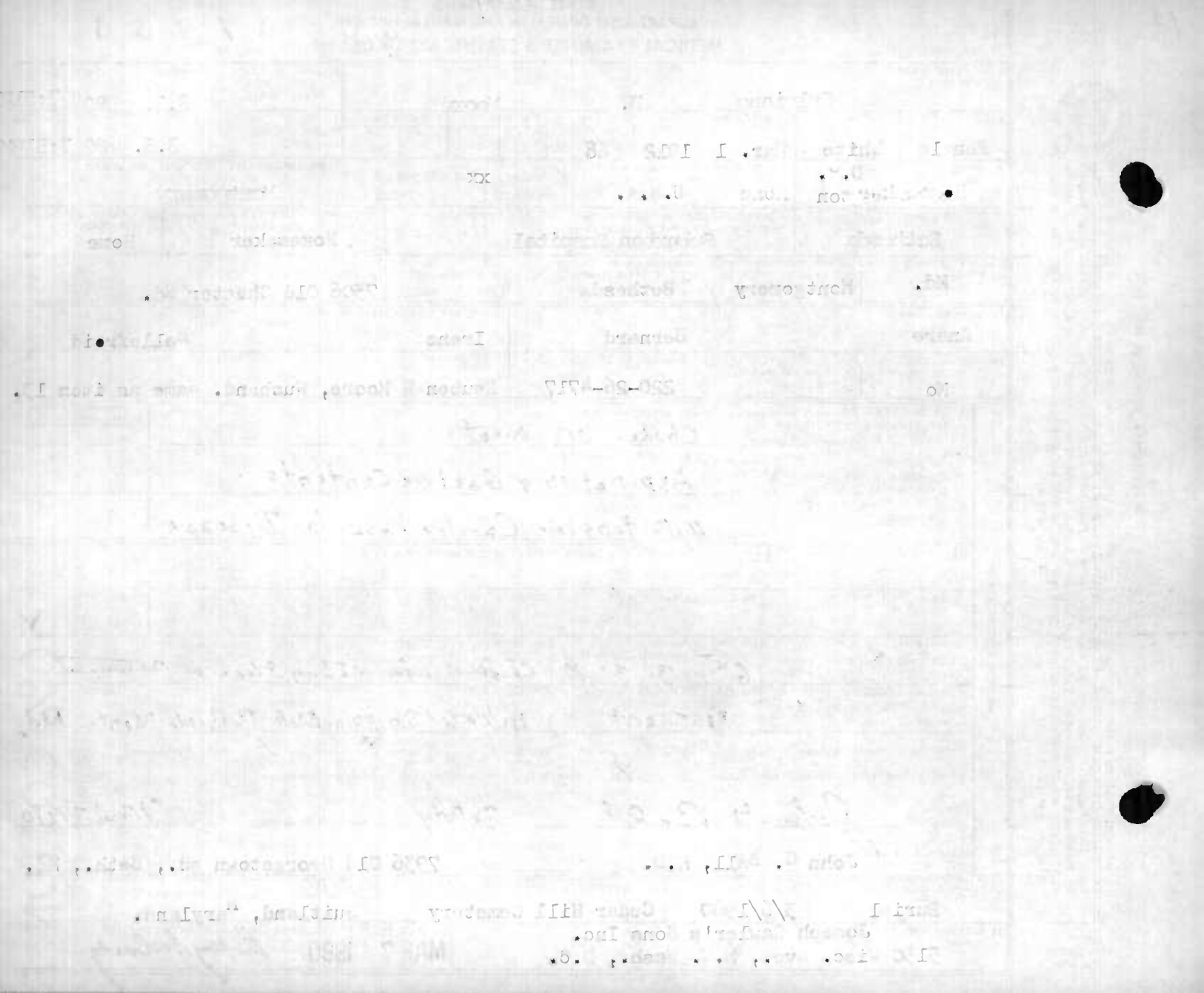
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DMMH - 17
(VR A15 ME (5))
15M7/77

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										07938 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)					FIRST Sylviane					MIDDLE B.					LAST Moore					2a. DATE KNOWN OF DEATH		2b. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR								
Female		White		Mar. 1 1912			68 YRS.		MONTHS		DAYS		HOURS		MIN.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH								
D.C. Washington					U.S.A.										Montgomery MD.								
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY								
Bethesda					Suburban Hospital					Homemaker					Home								
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS											
Md.			Montgomery			Bethesda			YES <input type="checkbox"/> NO <input type="checkbox"/>			7506 Old Chester Rd.											
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																		
FIRST MIDDLE LAST					FIRST MIDDLE LAST																		
Andre					Bernard					Irene					Bellefroid								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?					16b. SOCIAL SECURITY NO.					17. INFORMANT					ADDRESS								
No					220-26-4717					Reuben W Moore, Husband.					Same as item 13.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Choked on Meat.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aspiration of Gastric Contents.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive Cardiovascular Disease.</u>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?								
															YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
					6:30 P.M. 3. 3 1980					Choked when eating steak in restaurant													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					21f. LOCATION													
					Restaurant.					Wildwood Shopping Mall Bethesda Mont. Md.													
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																							
ACTUAL SIGNATURE					TITLE (SPECIFY)					DATE SIGNED													
John G. Ball					M.D. Deputy					March 3, 1980													
EXAMINER'S NAME (TYPE OR PRINT)					ADDRESS																		
John G. Ball, M.D.					7936 Old Georgetown Rd., Beth., Md.																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION								
Burial					3/6/1980					Cedar Hill Cemetery					Suitland, Maryland.								
24. FUNERAL DIRECTOR NAME					ADDRESS					25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE								
Joseph Gawler's Sons Inc.					5130 Wisc. Ave., N.W. Wash., D.C.					MAR 7 1980					Justing McCreedy								

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

07939

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) DAVID A. Moorman Sr.			2a. DATE OF DEATH MONTH MARCH DAY 30 YEAR 1980		2b. HOUR 3:50A
3. SEX MALE	4. RACE CAUC.	5. DATE OF BIRTH MONTH 7 DAY 4 YEAR 15	6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. Adventist Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver	12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE Md.			13b. COUNTY Pr. Geo.	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST Samuel MIDDLE LAST Moorman			15. MOTHER'S MAIDEN NAME FIRST Lucinda MIDDLE LAST Breeden		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 577-16-7878	17. INFORMANT ADDRESS Linda Moorman - above address		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary arrest 5751 DUE TO, OR AS A CONSEQUENCE OF (b) B. lateral lobar pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) Congestive heart failure					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Gangrene of the small bowel; Thrombotic pneumonia & GI bleeding					
19a. DATE OF OPERATION 3-20-80	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholecystitis; Dept's ulcer disease	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I (this hospital) attended the deceased from 1977 , 19____, to 3-30-80 , 19____, that I (we) last saw the deceased alive on 3-24-80 , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Charles Franklin Jr MD		DEGREE MD		22c. DATE SIGNED 3-30-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles Franklin Jr		22e. ADDRESS 11200 Larkwood Drw Silver Spring Md 20901			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/3/1980	23c. NAME OF CEMETERY OR CREMATORY Maryland Vet. Com.	23d. LOCATION CITY OR TOWN Cheltenham COUNTY Pr. Geo. STATE Md.		
24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc. Mt. Rainier, Md.			25a. DATE REC'D. BY REGISTRAR APR 7 1980	25b. REGISTRAR'S SIGNATURE Henry McQuay	

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

07940

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Lillian NMN Moten			2a. DATE OF DEATH MONTH DAY YEAR 3-27-80			2b. HOUR 9 ¹⁵ M			
3 SEX Female		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR JAN 23, 1893		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY Montg		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Richard Hill			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Della Adams			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 069-12-6852			17 INFORMANT ADDRESS Florence Powell (Niece) same as #13			18 CAUSE OF DEATH PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardio-respiratory arrest 20 & cardiac</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>2 yr. chronic heart syndrome 2 &</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>fractured aortic aorta</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>several years</u> <u>many years -</u>			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>multiple decubiti and prob. sepsis</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/25</u> , 19 <u>80</u> , to <u>3/27</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>3/27</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE F. W. BRENNWALD			DEGREE MD			22c. DATE SIGNED 3/28/80		22d. PHYSICIAN'S NAME (TYPE OR PRINT) F. W. BRENNWALD	
22e. ADDRESS 831 University Blvd E, Silver Spring			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL						
23b. DATE 4-5-80			23c. NAME OF CEMETERY OR CREMATORY Ash Mem. Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montg Md.			
24. FUNERAL DIRECTOR NAME George R. Snowden			ADDRESS 246 N. WASH. ST. Rockville, Md.			25a. DATE REC'D. BY REGISTRAR APR 7 1980		25b. REGISTRAR'S SIGNATURE P. H. H. H.	

MEDICAL CERTIFICATION



RECEIVED MAY 1 1964

U.S. DEPARTMENT OF AGRICULTURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0 0 7 9 4 1			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rodney F. Moulton				2b. HOUR 10:50 A.M.			
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 01 31 23		6 AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH DAKOTA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FIN.AIDE SPECIALIST		12b. KIND OF BUSINESS OR INDUSTRY govt.	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST FLOYD C. MOULTON		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GENA VIKEN		13e. STREET ADDRESS 624 AZALEA DR.,			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WWII 504-09-7521		17 INFORMANT ADDRESS SHIRLEY RUTH MOULTON (SAME AS 13e)			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio respiratory arrest							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes
4140 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Lung Disease							Months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Heart Disease							Months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/25, 1980, to 3/28, 1980, that (I) (we) last saw the deceased alive on 3/25, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]				DEGREE		22c. DATE SIGNED 3/25/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joel Schulman				22e. ADDRESS 9410 Old Georgetown Road			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 3-27-80		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA FAIRFAX VIRGINIA	
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY FUNERAL HOMES P/A				25a. DATE REC'D. BY REGISTRAR APR 2 1980		25b. REGISTRAR'S SIGNATURE [Signature]	

ROBERT A. LEWIS FURNACE HOMES PVA
 3-27-00
 METROPOLITAN CREW/DRY ALEXANDRIA FAIRFAX VIRGINIA
 RUC VILL

YES
 WILL
 504-09-7527
 SHIRLEY RUTH MONTGOMERY (SAME AS 1st)

FLOYD
 C.
 MONTGOMERY
 ROCKVILLE
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 624 AZALEA DR.
 ALLEN

BETHESSA
 SOUTH DAKOTA
 U.S.A.
 FILLMORE SPECIALIST DOVE

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										07942	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Bradley</i>		MIDDLE <i>Louis</i>		LAST <i>MULLINS</i>		2b. DATE OF DEATH		2c. DATE KNOWN ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <i>3-6-1980</i>	
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Dec. 2, 1960</i>		6. AGE (IN YEARS) LAST BIRTHDAY <i>19</i> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2d. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>March 6, 1980</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>UNEMPLOYED</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Kensington</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>10207 Drumm Avenue</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Donald D. Mullins</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Margaret J. Micozzi</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>219-80-1423</i>		17. INFORMANT <i>father</i> ADDRESS <i>same as 13e</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Injuries Severe</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <i>Trauma Auto. Accident</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR <i>4:10 P.M. 3-6 1980</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Passenger in car out of control - Hit tree</i>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Street</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>11706 Charles Rd. Wheaton Montgomery Md</i>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John B. Ball</i>		TITLE (SPECIFY) <i>Deputy</i>		MEDICAL EXAMINER				DATE SIGNED <i>March 6, 1980</i>			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Mar. 10, 1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Silver Spring Mont. Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Francis J. Collins</i>		500 University Blvd., W. Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR <i>MAR 10 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Anthony M. Collins</i>			

1990

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 07943							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARIE M. MURPHY					2a. DATE OF DEATH MONTH DAY YEAR March 3 1980			2b. HOUR 4:14P M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 7, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rhode Island		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. CITY OR TOWN New Hampshire Merrimack Concord					13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 3 Windsor Avenue		
14. FATHER'S NAME FIRST MIDDLE LAST George Dollar					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Sevigny				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII 033 22 1363		17. INFORMANT ADDRESS Gilbert J. Murphy See item 13					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory insufficiency and coma</u> 4275 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>approx. 36 days</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION Jan. 18, 1980		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED perforation of esophagus			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from Jan. 2, 1980, to Mar. 3, 1980, that (I) (we) lost s/he - the deceased alive on Mar. 3, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>Michael Swank</u> DEGREE								22c. DATE SIGNED Mar. 4, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Swank, M.D.					22e. ADDRESS National Naval Medical Center, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE Mar. 7, 1980		23c. NAME OF CEMETERY OR CREMATORY Blossom Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Concord, Mass.		
24. FUNERAL DIRECTOR NAME Robt. A. Pumphrey Funeral Home, Bethesda, Md.					25. DATE RECEIVED BY REGISTRAR MAR 10 1980		25b. REGISTRAR'S SIGNATURE <u>John G. Ball</u>		

RECEIVED
U.S. DEPARTMENT OF THE ARMY
WASHINGTON, D.C. 20315

100-100000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1511 BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 0 07944									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MILTON C. MURRAY					2a DATE OF DEATH MONTH DAY YEAR 3/2/80			2b HOUR 5⁰⁰ AM			
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 8/21/99		6 AGE (IN YEARS LAST BIRTHDAY) YRS. 80		7 UNDER 1 YEAR MONTHS DAYS 8 UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH TAKOMA PARK MD 20012					
10 CITY OR TOWN OF DEATH TAKOMA PARK MD		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SLIGO GARDENS				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DAIRY WKR.		12b KIND OF BUSINESS OR INDUSTRY SEAFEST DAIRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD.					13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring MD.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST GEORGE MURRAY					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JENNETTE W. HATCHER						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 577-03654		17 INFORMANT MARGA		ADDRESS MARGARET HIGBIE SAME AS #13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARCINOMA OF LUNG 1629 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from May 19 78 , to 3-2 1980 , that (I) (we) lost saw the deceased alive on 2-25 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b SIGNATURE [Signature]			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 3-2-80			
22d PHYSICIAN'S NAME (TYPE OR PRINT) JASON GEIGER MD.			22e ADDRESS 8830 CAMERON STREET SILVER SPRING MD 20910								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE 3/5/80		23c NAME OF CEMETERY OR CREMATORY PARKLAWN CEM.		23d LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONTGOMERY MD.				
24 FUNERAL DIRECTOR'S NAME DEVOL FUNERAL HOME			24b ADDRESS WASH. D.C.			25a DATE REC'D. BY REGISTRAR MAR 7 1980		25b REGISTRAR'S SIGNATURE [Signature]			

1911
No. 1
The following is a list of the plants
which have been introduced into the
United States from foreign countries
since the year 1900. The list is
based on the records of the Bureau of
Plant Industry, and is intended to
show the progress of the work of the
Bureau in this field.

The list is arranged in alphabetical
order of the names of the plants.
The names of the plants are given in
English, and are followed by the
names of the countries from which they
were introduced. The names of the
countries are given in English, and
are followed by the names of the
persons who introduced them. The
names of the persons are given in
English, and are followed by the
names of the countries from which they
were introduced. The names of the
countries are given in English, and
are followed by the names of the
persons who introduced them. The
names of the persons are given in
English, and are followed by the
names of the countries from which they
were introduced.

1980 MAR -5 AM 8:58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

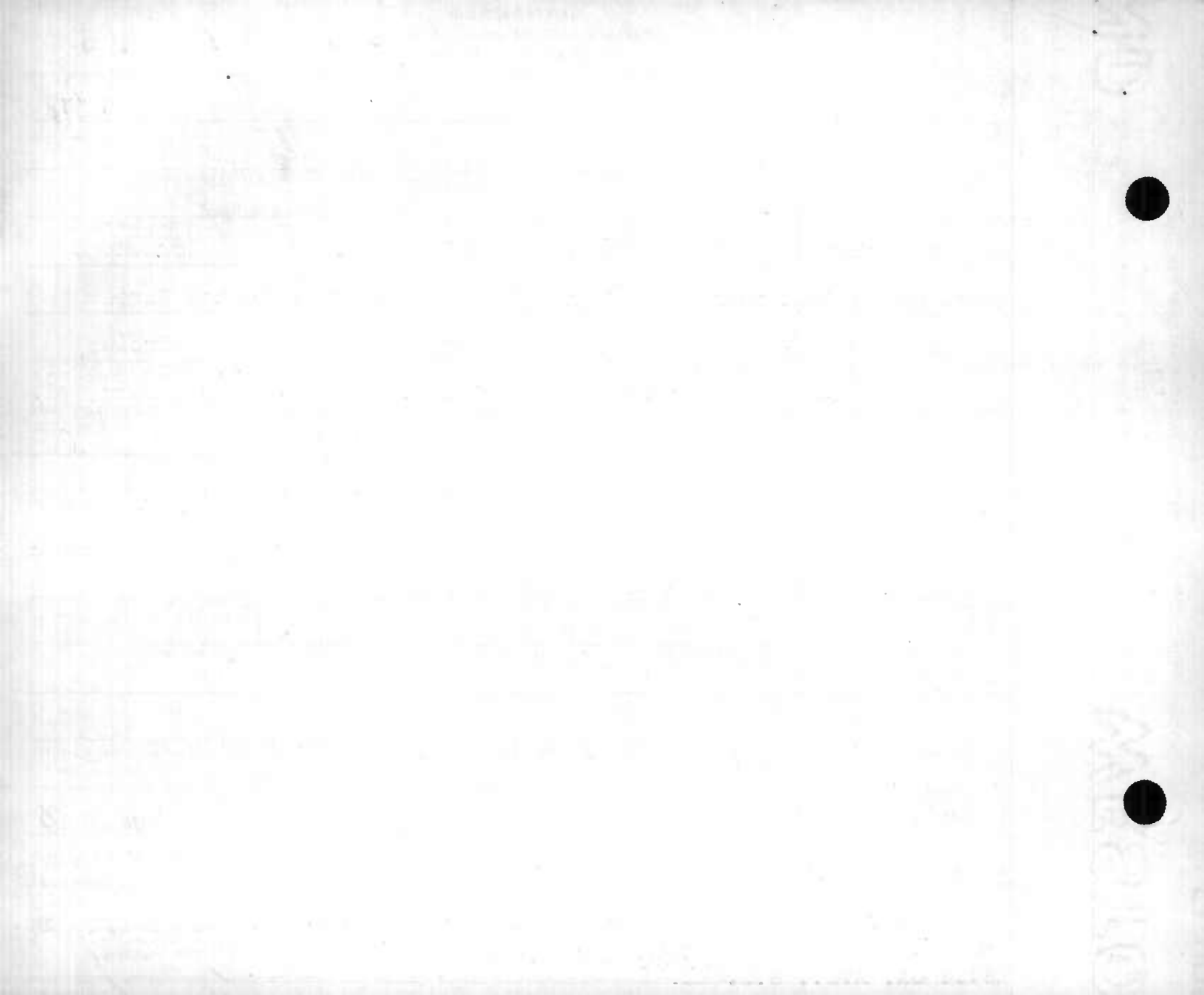
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 0 07945							
1. DECEASED NAME (TYPE OR PRINT) Virginia M. Myers					2a. DATE OF DEATH MONTH DAY YEAR March 4, 1980					2b. HOUR 7:37 P.M.		
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 1/18/01			6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2307 Eccleston Street				
14. FATHER'S NAME FIRST MIDDLE LAST Asa A Sheetz					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Dirting							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none		17. INFORMANT (son) Douglas L. Myers			17a. ADDRESS 44 Mt. Vernon Ave., Frederickburg, Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Pulmonary hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>30 min</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immed</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Acute myocardial infarction</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (1) (this hospital) attended the deceased from <u>3 Mar 80</u> to <u>4 Mar 80</u> , that (1) (we) last saw the deceased alive on <u>4 Mar 80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)												
22b. SIGNATURE <u>Alan I. Kermaier, MD</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>4 Mar 80</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ALAN I. KERMAIER, MD</u>					22e. ADDRESS <u>9801 GEORGIA AVE S.S. MD 20902</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>3-7-80</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Rockville Montgomery Md.</u>						
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>					24a. ADDRESS <u>8434 Ga. Ave., S.S., Md.</u>			24b. DATE REC'D. BY REGISTRAR <u>10 1980</u>			24c. REGISTRAR'S SIGNATURE <u>Anthony McElreath</u>	

BP

DHM-16 20M
(VRA 15, 4) 7/78



251. ROBINSON'S SIGNATURE
Robt. H. Robinson

BP _____
DHMH - 17
(VR A15 ME (5))
15M 7/76

241100 .L 210455

02/2/94

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

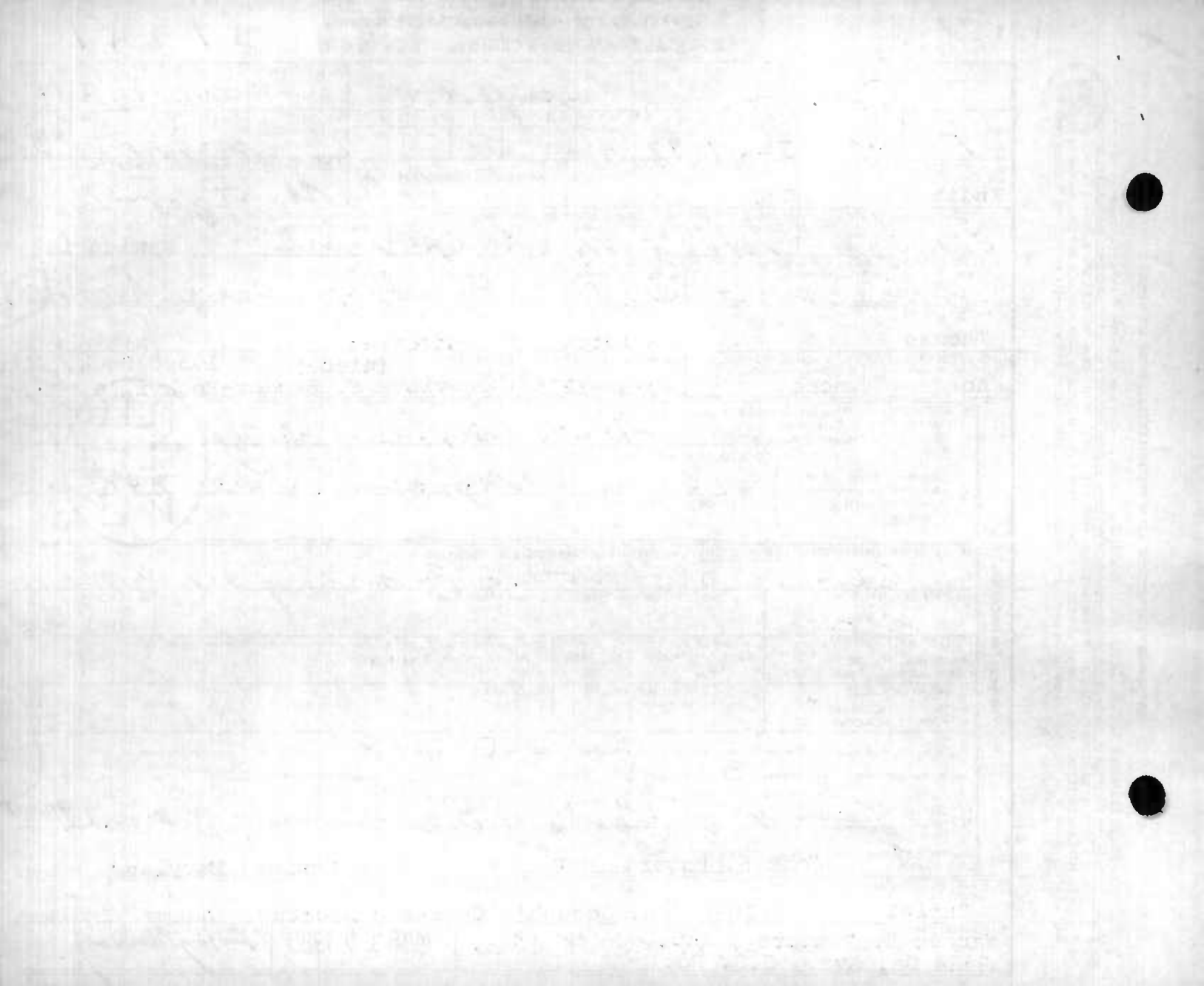
BP
DHMH - 17
(VR A15 ME 5)
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

07947

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI. DEATH MATED		MONTH		DAY		YEAR		2b. HOUR 5:58 M			
Celesto						Mylotte		March 3, 1980											
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR 1:30 M	
F	W	Jan 7 1928		87 YRS.						March 4, 1980									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Indiana		USA				Montgomery, MD.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Sil. Spg.		10800 Georgia Ave. Apt. 312		Retired		Manicurist													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
MD		Mont		Sil. Spg		YES <input checked="" type="checkbox"/>		10800 Georgia Ave. Apt. 312											
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST							
Thomas				Mylotte		Margaret													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
no		none		540-32-2215		Genevieve T. Bender-Rockville, Md.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
4391		V.R.																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		Chronic Obstructive Pulmonary Dis. V.R.																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?															
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED															
John S. Rogers, DME		M.D. DME		March 9, 1980															
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																	
John S. Rogers, DME		Silver Spring, Maryland																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE													
Burial		3-8-1980		St. Joseph's Cemetery		Decatur Adams Indiana													
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
8434 Ga. Ave., S.S. Md.		1000 E. McLean		MAR 10 1980		Pumphrey													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "Other" in 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

clear = Medical Examiner's Signature

20
FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

0 0 7 9 4 8

1. DECEASED NAME (TYPE OR PRINT) ELIAS GUY Nace			2a. DATE OF DEATH MONTH DAY YEAR 3-16-80			2b. HOUR 8:05 AM			
3. SEX M		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR 4-26-95		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENN		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSE ATTENDANT		12b. KIND OF BUSINESS OR INDUSTRY HOSPITAL	
13a. STATE MD		13b. COUNTY PG		13c. CITY OR TOWN LAUREL		13d. STREET ADDRESS 8906 ROYAL RIDGE LANE			
14. FATHER'S NAME FIRST MIDDLE LAST PHILIP NACE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JANE DIVIL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 358-10-0071		17. INFORMANT ADDRESS PAUL NACE - ABOVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: Septic Shock 2765 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Dehydration, Arteriosclerosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3/15 19 80 to 3/16 19 80 , that (I) was last saw the deceased alive on 3/15 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Antonio G. Uy M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/16/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANTONIO G. UY M.D.		22e. ADDRESS 831 Univ Blvd, Silver Spring, MD 20903							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE MARCH 18, 1980		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW MEM.		23d. LOCATION CITY OR TOWN COUNTY STATE CATONSVILLE MD			
24. FUNERAL DIRECTOR NAME DONACDSON FUNERAL HOME		ADDRESS LAUREL MD		25a. DATE REC'D. BY REGISTRAR MAR 24 1980		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

BP.

8.11.10

STATE OF MASSACHUSETTS

IN SENATE,

January 11, 1910.

REPORT

OF THE

COMMISSIONERS OF THE

DEPARTMENT OF

AGRICULTURE

AND

FOREST SERVICE

FOR THE YEAR

1909

AND

THE FIRST SIX MONTHS

OF 1910

AS REPORTED

TO THE SENATE

AND HOUSE OF

REPRESENTATIVES

OF THE COMMONWEALTH

OF THE

COMMISSIONERS OF THE

DEPARTMENT OF

AGRICULTURE

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AS REPORTED

TO THE SENATE

AND HOUSE OF

REPRESENTATIVES

OF THE COMMONWEALTH

OF THE

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

0 0 7 9 4 9

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Clarence Naylor			2a DATE OF DEATH MONTH DAY YEAR March 6, 1980			2b HOUR 10:18a M				
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR Oct. 20, 1920		6 AGE (IN YEARS LAST BIRTHDAY) 59 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10 CITY OR TOWN OF DEATH Olney		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance		12b KIND OF BUSINESS OR INDUSTRY School Bd.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a STATE Md.		13b COUNTY Montg.		13c CITY OR TOWN Dickerson		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 18415 Comus Road		
14 FATHER'S NAME FIRST MIDDLE LAST Arthur E. Naylor					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen M. Bowie					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. 225-28-7233		17 INFORMANT ADDRESS Helen Hebron (Sister) same as #13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest 410- DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Atherosclerotic Heart Disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 40 min.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Cirrhosis										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 3-1 , 19 80 , to 3-6 , 19 80 , that (I) (we) last saw the deceased alive on 3-6 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE Michael A. Bolognese M.D.					DEGREE M.D.			22c DATE SIGNED 3-6-80		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Michael A. Bolognese M.D.					22e ADDRESS 19261 Montgomery Village Ave Gaithersburg, Md. 20760					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 3-11-80		23c NAME OF CEMETERY OR CREMATORY St. Paul Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Della, Frederick, Md.			
24 FUNERAL DIRECTOR NAME George R. Snowden					24b ADDRESS 246 N. Washington Street Rockville, Md. 20850		25a DATE REC'D. BY REGISTRAR MAR 12 1980		25b REGISTRAR'S SIGNATURE Robert McBratney	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10:18a March 6, 1980 Clarence Taylor

Black 100-20-7520
Westmoreland County
Westmoreland General Hospital
Pittsburgh, Pa 15201
John F. Taylor

100-20-7520 John Taylor (Student) age 22-13

100-20-7520 John Taylor (Student) age 22-13
MAR 11 1980
St. Paul Center
340 N. Washington Street
Pittsburgh, Pa 15201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

0 7 9 5 0

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Emory C. Naylor			2a DATE OF DEATH MONTH DAY YEAR March 6, 1980			2b HOUR 4:38 AM					
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR June 17, 1900		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lawyer		12b KIND OF BUSINESS OR INDUSTRY			
13a STATE Maryland			13b COUNTY Montgomery		13c CITY OR TOWN Sil. Spring		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 30 Bryants Nursery Rd.		
14 FATHER'S NAME FIRST MIDDLE LAST Henry Naylor			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Bestor			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes				16b SOCIAL SECURITY NO. 678 16 8157	
17 INFORMANT (wife) Mrs. Henrietta S. Naylor #13			18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Severe Atherosclerotic Cardiovascular Disease</u> (c) <u>Coronary Artery Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes 2 years 2 years								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Obstructive Airways Disease - Emphysematous type</u>											
19a DATE OF OPERATION 3-5-80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Acute Thrombosis Left common iliac artery</u>				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>March 3, 1980</u> , to <u>March 6, 1980</u> , that (I) (we) lost saw the deceased alive on <u>March 5, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Frank J. Mayo, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3-6-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank J. Mayo				22e. ADDRESS 16320 Frederick Road, Gaithersburg, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/8/80		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Md.					
24. FUNERAL DIRECTOR NAME W.W. Taltavull Funeral Home XXXXXXX 4748 Wisc. Ave. D.C.				25a. DATE REC'D. BY REGISTRAR MAR 10 1980		25b. REGISTRAR'S SIGNATURE Anthony McCreedy					

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

June 17, 1960

NY 100

Mr. J. Edgar Hoover

Director, FBI

Re: [illegible]

Very truly yours,

(S)

Walter E. [illegible]

Special Agent in Charge

1000 Broadway, New York 10, N.Y.

Very truly yours,

Walter E. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		March 6, 1980		6 ⁰⁰ P.M.	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		# UNDER 1 YEAR		# UNDER 24 HRS	
Female		Caucasian		7/19/1899		80 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
D.C.		U.S.A.				Montgomery County, MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Chevy Chase		Bethesda Retirement & Nursing Center						Homemaker		Home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Montgomery		Chevy Chase		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8908 Kensington Parkway			
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
James Kelly				Elizabeth Sewell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17 INFORMANT		ADDRESS					
No		215-48-0287		J. Bernard Nebel		10501 Magnolia Court Silver Spring, MD					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Congestive failure</i>											
4409 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerosis</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <i>Pneumonia</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
None						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 19 <i>33</i> to <i>present</i> 19 <i>80</i> , that (I) (we) lost saw the deceased alive on <i>Feb 29</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
<i>John B. Umhau</i>				<i>MD</i>				<i>3/6/80</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
<i>John B. Umhau</i>				<i>8805 Conn. Ave. Chevy Chase Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE			
Burial		3/10/80		Arlington Nat'l. Cem.		Arlington, Virginia					
24 FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
<i>Robert A. Pumphrey</i>				<i>Funeral Homes, P.A.</i>				<i>Mar 11 1980</i>			
7557 Wisconsin Ave., Bethesda, MD											

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FOR STATE REGISTRAR											
DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) DON FRANK NEUFELD						2a. DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> 3 3 19 80 7:36A					
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH 12 DAY 5 YEAR 1965	6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD 23 3 19 80 7:36A			2d. HOUR		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 1 minster			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silverspring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 705 Langley Dr.		
14. FATHER'S NAME FIRST Jacob MIDDLE Neufeld LAST Neufeld						15. MOTHER'S MAIDEN NAME FIRST Ann MIDDLE Neufeld LAST Neufeld					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215 38 6121			17. INFORMANT ADDRESS Berney R. Neufeld (son)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE [Signature]				TITLE (SPECIFY) M.D. Dep				MEDICAL EXAMINER DATE SIGNED March 31 1980			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE MAR. 6, 1980		23c. NAME OF CEMETERY OR CREMATORY Frank Lincoln Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P. G. Md.	
24. FUNERAL DIRECTOR NAME Inform Funeral Home, 9400 W. 254 Carroll St. W.D. ADDRESS				25a. DATE REC'D. BY REGISTRAR MAR 6 1980				25b. REGISTRAR'S SIGNATURE [Signature]			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1- STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTI- MATED		2b. HOUR	
Mary Willie Neugent						3/4 1980		P. 12:45	
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	Black	May 1, 1895	84 YRS.			3/4 1980		P. 12:45	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.		U.S.A.				Montgomery County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Brookeville		21021 New Hampshire Avenue				Teacher (retired)			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS					
Maryland	Montgomery	Brookeville		21021 New Hampshire Avenue					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
William T. Neugent			Ellen E. Holland						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
No			225-42-8495		Maude Hill (Sister) 20001 New Hampshire Av. Brinklow, Md. 20727				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>carcinoma of the pancreas.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>None</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
None									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
			P.M. 19		None				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED			
<i>John S. Rogers</i>			M.D. Deputy			3/4/80			
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS						
John S. Rogers, M.D.			1919 Seminary Road Silver Spring, Montgomery, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			3-8-80		Ash Memorial Cemetery		Sandy Spring, Montg.		
24. FUNERAL DIRECTOR NAME			25a. DATE RECD. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
George R. Snowden			246 N. Washington Street Rockville, Md. 20850			MAR 10 1980 <i>John S. Rogers</i>			

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DHMH - 17
(VR A15 ME (5))
30M 7/73

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Teacher (female)

10000

10000

10000

John L. Holland

William T. Holland

SS: 45-44-4 (female) (sister) 10000

10000

10000

John L. Holland

William T. Holland

10000

10000

10000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 07954	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) THOMAS M. NICHOLS										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 3 DAY 3 YEAR 80	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH Sept. DAY 19 YEAR 1979		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 5		IF UNDER 1 YR. MONTHS 5 DAYS 		2b. DATE PRONOUNCED DEAD MONTH 3 DAY 3 YEAR 80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County	
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 409 Silver Spring Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY None	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 409 Silver Spring Avenue			
14. FATHER'S NAME FIRST Howard MIDDLE V. LAST Nichols					15. MOTHER'S MAIDEN NAME FIRST Nancy MIDDLE J. LAST Palmer						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 213-94-3019		17. INFORMANT ADDRESS Howard V. Nichols-Address same as #13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 7980 IMMEDIATE CAUSE (a) Sudden infant death syndrome Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Margie A. Korell				TITLE (SPECIFY) Assistant				DATE SIGNED 3-4-80			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Mar/6/80		23c. NAME OF CEMETERY OR CREMATORY West Liberty Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Union Township-Poweshiek-Iowa			
24. FUNERAL DIRECTOR NAME Chambers Funeral Home-Silver Spring, Maryland						25a. DATE REC'D. BY REGISTRAR MAR 10 1980		25b. REGISTRAR'S SIGNATURE Dorothy McCready			

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University of Chicago Press

CHICAGO, ILL. 60637



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MAMIE Florence Nicholson			2a. DATE OF DEATH MONTH DAY YEAR 3 15 80			2b. HOUR 7:25 P.M.				
3. SEX FEMALE		4. RACE CAUCASION		5. DATE OF BIRTH MONTH DAY YEAR 6 18 82		6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 9 1 15		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H. Maker		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Maryland			13b. COUNTY Mont.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Zacharias T. Musgrove			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma - Craver			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				
16a. SOCIAL SECURITY NO. 220-48-1932 T			17. INFORMANT ADDRESS Allen L. Nicholson Biglerville, Pa.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEART FAILURE 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC CARDIO - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) VASCULAR DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MO										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from 19 76 to 15 MAR 19 80 , that (I) (myself) lost saw the deceased alive on 14 MAR 19 80 , and that in (my) (best) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22a. SIGNATURE Walter E. Goetz						DEGREE MD		22c. DATE SIGNED 15 MAR 80		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOZH MD						22d. ADDRESS 2309 SHOREFIELD ROAD WHEATON MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE March 19, 1980		23c. NAME OF CEMETERY OR CREMATORY St. John's		23d. LOCATION CITY OR TOWN COUNTY STATE Olney Mont. Md.			
24. FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20760						25. DATE RECD. BY REGISTRAR MAR 19 1980		25b. REGISTRAR'S SIGNATURE Walter E. Goetz		

3 12 30 1929

NAME F. Nicholson

FEMALE CACASION 2 18 32 1929

U.S.A.

Items 18 & 22a G541 3/18/80 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE dad REGISTRAR

REG. NO. 07956

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
Bennie Nix			2a. DATE KNOWN OF DEATH			2b. HOUR		
3. SEX			4. RACE			5. DATE OF BIRTH		
Male			Black			Jul 2 1914		
6. AGE (IN YEARS)			7. IF UNDER 1 YR.			8. IF UNDER 24 HRS.		
65 YRS.			MONTHS DAYS			HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED		
S. C.			USA			NEVER MARRIED		
9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		
Montgomery County, MD.			Takoma Park			Washington Adventist Hospital		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13a. STATE		
Gas Light Co.			None			Md.		
13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY (LIMITS)?		
P.G.			Hyattsville			YES NO		
13e. STREET ADDRESS			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
2512 Vanburn Street			James Nix, Sr.			Clara Dunbar		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
Yes			Unk			Mrs. Louise Nix/wife/same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: Undetermined								
7999 IMMEDIATE CAUSE (a) _____								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								
(b) _____								
DUE TO, OR AS A CONSEQUENCE OF								
(c) _____								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?
								YES NO
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
			HOUR A.M. MONTH DAY YEAR					
21d. INJURY OCCURRED WHILE AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION		
						CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
			Assistant			2/18/80		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			BALTO., MD.		
Ann M. Dixon, M.D.			111 Penn St.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial			2-23-80			Lincoln Memorial		
23d. LOCATION			CITY OR TOWN			COUNTY STATE		
Sutland,			Md.					
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
NAME			FEB 26 1980			Anthony McCreedy		
John T. Rhines Co., 3015 12th St., N.E., D.C.								

170 1 1/2 0
175



Handwritten signature or text, possibly "B. J. ..."

Handwritten text, possibly "FEB 2 1908"

TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 0 7 9 5 7	
FOR STATE REGISTRAR				REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Anthony C. Nocella				2a. DATE OF DEATH MONTH DAY YEAR 3/19/80				2b. HOUR M			
3. SEX Male		4. RACE C		5. DATE OF BIRTH MONTH DAY YEAR 6/30/03		6. AGE (IN YEARS (LAST BIRTHDAY)) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ARCHITECT		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN KENSINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10807 STELLA COURT	
14. FATHER'S NAME FIRST MIDDLE LAST COSMO NOCELLA				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 123-10-9704		17. INFORMANT MARIE A. NOCELLA				ADDRESS SAME AS 13 WIFE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2500 IMMEDIATE CAUSE (a) Generalized arteriosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3-14-80, 1980, to 3-19-80, 1980, that (I) (we) last saw the deceased alive on 3-19-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE L. H. Beets NUNEZ										22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. H. Beets NUNEZ										22e. ADDRESS 8218 Gifford Ave Belt Road, MD 20014	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 3/22/80		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN		23d. LOCATION BRENTWOOD		23e. COUNTY PRT GEO	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR MAR 21 1980				25b. REGISTRAR'S SIGNATURE Rising McCreedy			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO. 07958							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FERN B. NORTON					2a. DATE OF DEATH MONTH DAY YEAR 3-19-80			2b. HOUR 6:15 P.M.	
3 SEX FEMALE		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR 2 5 1898		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Wash. Post	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Sil. Spring					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9507 Evergreen Street,		
14. FATHER'S NAME FIRST MIDDLE LAST Abner Bramlett					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosetta Keithley				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none		17. INFORMANT (husband) ADDRESS Robert S. Norton, Sr. (same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 2780 IMMEDIATE CAUSE (a) Cardio-respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cor pulmonale DUE TO, OR AS A CONSEQUENCE OF (c) O.C.s, I.T. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from March 17, 1980, to March 27, 1980, that (I) (we) lost saw the deceased alive on March 19, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE KIRK E. FURR MD					DEGREE		22c. DATE SIGNED 3/19/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KIRK E. FURR					22e. ADDRESS 4401 Old Georgetown Rd				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3-20-80		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alex. Fairfax Va.			
24. FUNERAL DIRECTOR NAME Warner E. Pumphrey, Inc., 8434 Ga. Ave., S.S. Md.					25a. DATE REC'D. BY REGISTRAR MAR 24 1980		25b. REGISTRAR'S SIGNATURE Kirk E. Furr		

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REMARKS :

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 07959

1. DECEASED NAME (TYPE OR PRINT) MICHAEL JOSEPH NUGENT			2a. DATE OF DEATH MONTH DAY YEAR 3-17-80			2b. HOUR 7 PM				
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Nov. 20, 1915		6 AGE (IN YEARS LAST BIRTHDAY) 64		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN YRS.		
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Dupont Co.		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland			13c. COUNTY P.G. Co.		13d. CITY OR TOWN Laurel		13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS 15615 Dorset Rd. Apt. 101	
14. FATHER'S NAME FIRST MIDDLE LAST Michael J. Nugent				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Noon						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 214-03-5061		17. INFORMANT ADDRESS Elsie A. Nugent same as #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coma 1539 DUE TO, OR AS A CONSEQUENCE OF (b) Septicemia + Bacteria Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Adenocarcinoma of colon								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min few months 4 1/2 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3/17/80 to 3/17 , 19 82 , that (I) (we) last saw the deceased alive on 3/17 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE E. LEVIR			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/17/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDGAR H. LEVIR			22e. ADDRESS 8630 FENTON ST.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/21/80		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Burtonsville, Mont. Md.			
24. FUNERAL DIRECTOR ELECK LAUREL FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel, Md. 20810						25a. DATE REC'D. BY REGISTRAR MAR 19 1980		25b. REGISTRAR'S SIGNATURE Fitzgerald		



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0007960			
1. DECEASED NAME (TYPE OR PRINT) Ethel M. Oberlin				2a. DATE OF DEATH MONTH DAY YEAR March 14, 1980			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec. 9, 1888		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery, MD	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Montg. 13c. CITY OR TOWN Kensington 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 4003 Spruell Dr.			
14. FATHER'S NAME FIRST MIDDLE LAST Milton W. Mc Farland				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Abigail Cline			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220 44 3474		17. INFORMANT ADDRESS 2813 Byron St. Silver Sp., Md.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) myocardial infarction, acute 410- DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from August 1977 to 3/14 , 19 80 , that (I) (we) last saw the deceased alive on 4/15 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Lewis Cahill DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/14/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis Cahill, M.D.				22e. ADDRESS 5411 Cedar Lane Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/14/80		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria, Va.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND				25a. DATE REC'D. BY REGISTRAR MAR 19 1980		25b. REGISTRAR'S SIGNATURE Henry McBrady	

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CLEARED with MED EXAMINER

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 0007961									
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR MIN. PM	
Fuji		Moriyama		Oda		March		1,		1980 10:30 PM	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY) YRS		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN.	
Female		White		Oct. 19 1891		88					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				MD.	
Japan		Perm. Resident				Montgomery					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY					
S.S.		15536 New Hampshire Ave,		Housewife		Home					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS	
Md.		Mont.		S.S.						15536 New Hampshire Ave	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Koichi Kusuda		Iro								Unknown	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		Same as ADDRESS Above					
None		216 58 7616		Shizuko		Qualkinbush (Daughter)					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
496-		CACHEXIA - INANITION		INTERSTITIAL PULM FIBROSIS		YRS					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF		CHRONIC OBST. Lung Dis.		YRS			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		ARTERIOSCLEROTIC C.V.D.									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21a INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from 1/21/65 to 3/1/80, that (I) (we) last saw the deceased alive on 2/24/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b SIGNATURE DEGREE		22c DATE SIGNED							
D. R. LEWIS MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		3/3/80							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE					
Cremation		Mar. 5, 1980		Fort Lincoln Crem.		Brentwood P.G. Md.					
24 FUNERAL DIRECTOR NAME		24b ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
Hines/Rinaldi F.H.		11800 N.H. Ave., Sil. Spr. Md.		MAR 6 1980		Larkin McCready					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		VICTOR M. OJEDA 2							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Victor M.						OJeda.		Mar. 24, 1980	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Male		White.		Jan 26 1939		41 YRS		9:10 A M	
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
PUERTO RICO		U. S. A.				Montgomery, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Takoma Park.		Washington Adventist Hospital.		Body Shop Operator.					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. CITY OR TOWN		13c. CITY LIMITS?		13d. STREET ADDRESS	
Washington, D. C.		D. C.		YES <input type="checkbox"/> NO <input type="checkbox"/>		7051 Spring Pl. N. W.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		No		053-46-8747		Julio M. OJEDA, 1356 Langley Way Hyattsville, Md.	
OJEDA		Julia.							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		410 -		CARDIAC ARREST		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		b) ACUTE MYOCARDIAL INFARCTION		3 weeks		DUE TO, OR AS A CONSEQUENCE OF			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
N/A		N/A		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 9-6-1980 to 3-19-1980, that (2) we lost saw the deceased alive on 3-19-1980, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did not) view the body after death.		22b. SIGNATURE K. Joseph Mathew, M.D.		22c. DATE SIGNED 3-25-80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
K. Joseph Mathew, M.D.		3700-East-West-Highway S# 100 - md							
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		March 29, 1980		Gate of Heaven (Ches) Spg Mount, Md.					
24. FUNERAL DIRECTOR		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR		24d. REGISTRAR'S SIGNATURE			
Arthur Walters		254 Carroll St. N.		MAR 28 1980					

WASHINGTON, D. C. 20540

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Director

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PUERTO RICO

Admission Ticket, Body Shop Operator

1001 Spring St. N. W.

D. C.

Tulsa

Washington

023-46-2377-1010 N. W. 1936

Washington, D. C. 20540

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR			REG. NO. 0 0 7 9 6 3							
1. DECEASED NAME (TYPE OR PRINT) CLARENCE MAGNE OLSEN			2a. DATE OF DEATH MONTH DAY YEAR MARCH 31, 1980				2b. HOUR 6:55 ^P M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR NOVEMBER 24, 1914		6. AGE (IN YEARS (LAST BIRTHDAY)) 65 YRS.		7. # UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE CLINICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) seaman		12b. KIND OF BUSINESS OR INDUSTRY oil tanker		
13a. STATE NEW YORK			13b. COUNTY Suffolk		13c. CITY OR TOWN Smithtown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4 HILLSIDE AVENUE 11780	
14. FATHER'S NAME FIRST MIDDLE LAST Kristen Olsen			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO N/A		17. INFORMANT ADDRESS MRS. LILLIAN OLSEN (WIFE) ABOVE		18. SAME AS ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY ARTERY DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 HRS</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>PERICARDIAL AORTIC REGURGITATION. AORTIC VALVE REPLACEMENT CORONARY BYPASS</u>										
19a. DATE OF OPERATION MARCH 31, 1980			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CORONARY INSUFFICIENCY			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (this hospital) attended the deceased from <u>MARCH 30, 1980</u> , to <u>MARCH 31, 1980</u> , that (we) last saw the deceased alive on <u>MARCH 31, 1980</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death.)										
22b. SIGNATURE <u>John J. Schier MD</u>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>APRIL 1, 1980</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOHN J. SCHIER, MD</u>			22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MD. 20205							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Apr. 3, 1980		23c. NAME OF CEMETERY OR CREMATORY St. James Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE St. James, New York			
24. FUNERAL DIRECTOR NAME Pearson's Funeral Home			ADDRESS Falls Church, Va. 22046			25a. DATE REC'D. BY REGISTRAR APR 7 1980		25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>		

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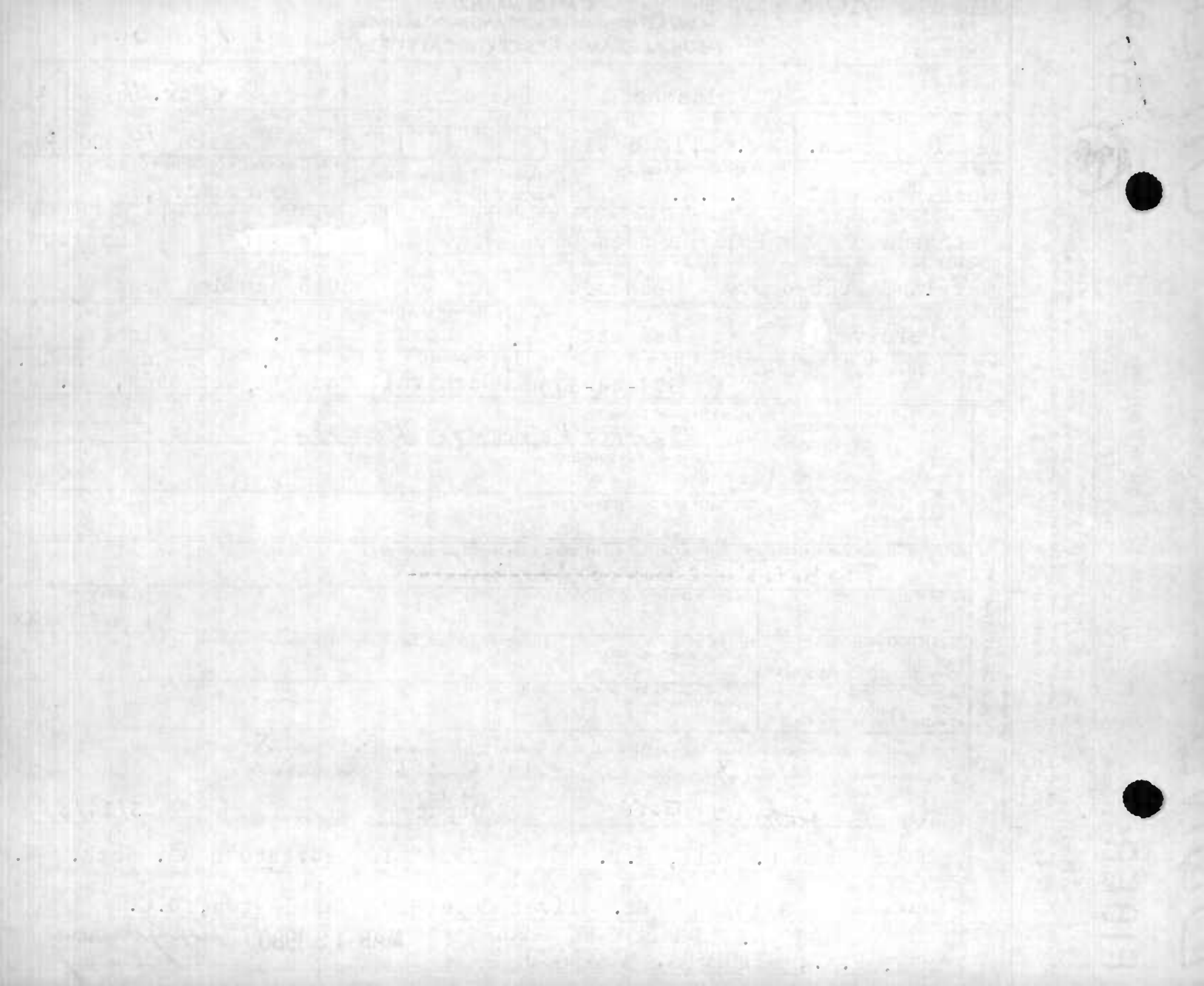
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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07964
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Alice Elizabeth Padgett								Mar. 14 19 80								A M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Female	Cauca.	Nov. 5, 1898		81 YRS.						March 14 1980						4 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH								MD.	
Washington DC		U.S.A.						Montgomery,									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Bethesda		8013 Hampden Lane		Professor		Education											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8013 Hampden Lane									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Percival Padgett, Sr.		Rosa M. Richards															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Jr. ADDRESS											
NO		579-44-5480		Percival Padgett, Bethesda, Md.		8009 Hampden Ln.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular Disease.</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Diabetes - Chronic - Alcohol -</u>																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE		TITLE (SPECIFY) Deputy		M.D.		MEDICAL EXAMINER		DATE SIGNED		3/14/80							
EXAMINER'S NAME (TYPE OR PRINT)		John G. Ball, M.D.		ADDRESS		7936 Old Georgetown Rd. Beth. Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		3/18/80		Mt. Olivet Cemetery		Washington, D.C.											
24. FUNERAL DIRECTOR NAME		ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
				MAR 19 1980		Anthony McCreedy											

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

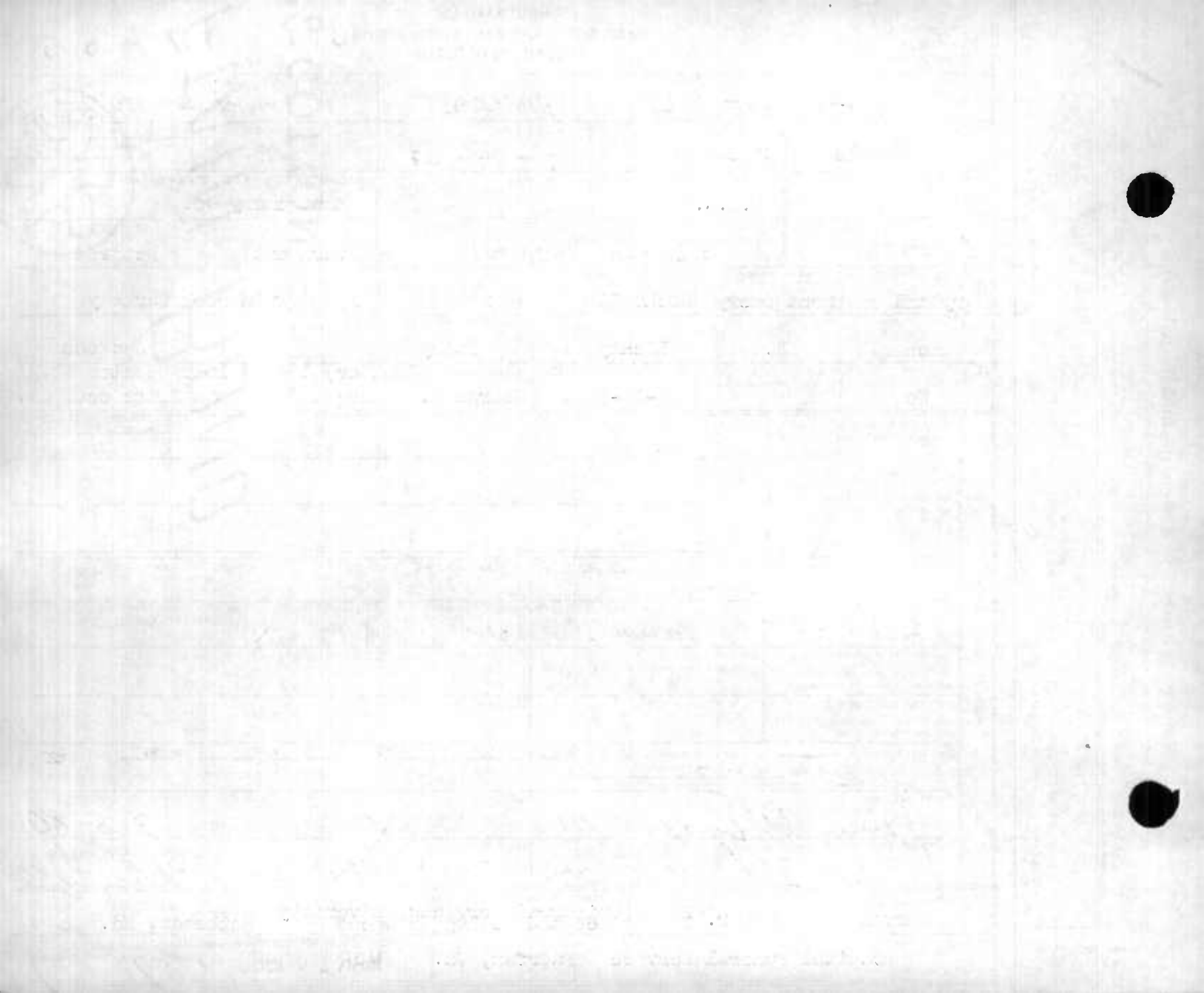
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) KATHERINE L. PANCOAST			2a. DATE OF DEATH MONTH DAY YEAR March 5 1980			2b. HOUR 3:30 A.M.			
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 9-24-06		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS		7 IF UNDER 1 YEAR MONTHS DAYS 73	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD.			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Government			12b KIND OF BUSINESS OR INDUSTRY Retired	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Ben R. Lichty			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy Jackson			13e. STREET ADDRESS 13202 Twinbrook Parkway			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 094-12-3064		17 INFORMANT (Brother) George E. Lichty			ADDRESS 1818 Webster St. San Francisco, Ca.		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Lung, Oat Cell Type 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None									
19a. DATE OF OPERATION 2.27.80			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Lung Cancer			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3.7 1980			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 2.13 19 80 to 3.5 19 80 , that (I) (we) last saw the deceased alive on 3.7 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James W. Egan M.D.						DEGREE M.D.		22c. DATE SIGNED 3.5.80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES W. EGAN						22e. ADDRESS 5413 Cedar Ln Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE Mar. 5 1980		23c. NAME OF CEMETERY OR CREMATORY Uniformed Services University of the Health Sciences		23d. LOCATION CITY OR TOWN COUNTY STATE Bethesda, Md.		
24 FUNERAL DIRECTOR NAME Capitol Funeral Service						ADDRESS Fairfax, Va.		25a. DATE REC'D. BY REGISTRAR MAR 10 1980	
25b. REGISTRAR'S SIGNATURE Anthony McCreedy									



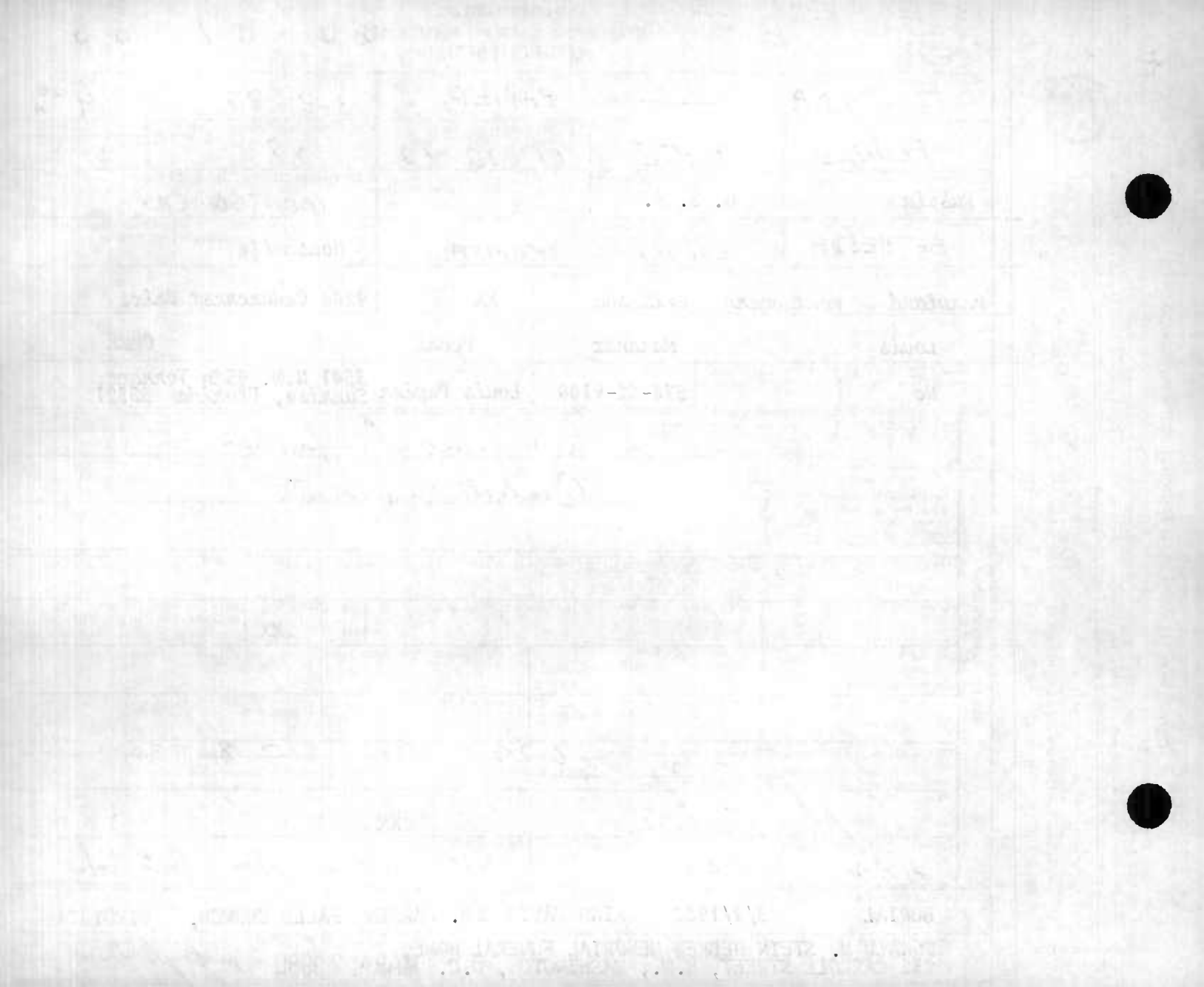
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 0 0 7 9 6 6			
1. FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IDA — PAPIER				2a. DATE OF DEATH MONTH DAY YEAR 3-8-80				2b. HOUR 4 ²⁵ AM			
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 01 12 92		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD							
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9206 Cedarcrest Drive							
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda									
14 FATHER'S NAME FIRST MIDDLE LAST Louis Marantz				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Okun									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-82-9100		17 INFORMANT ADDRESS Louis Papier 3541 N.W. 95th Terrace Sunrise, Florida 33321									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Dilated cardiomyopathy</u> (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>2-29-80</u> , 19 <u>80</u> , to <u>3-8-80</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>3-7-80</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE H. Bahar				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3-8-80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HADI BAHAR				22e. ADDRESS 8218 Wisconsin Ave. Bethesda									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/9/1980		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEM. GARDEN		23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH, VIRGINIA							
24 FUNERAL DIRECTOR NAME DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME				24b. DATE REC'D. BY REGISTRAR MAR 17 1980		24c. REGISTRAR'S SIGNATURE H. H. H. H.							
232 CARROLL STREET, N.W., WASHINGTON, D.C.													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOUR MIN.	
Olive Gilliss PARKS		March 23 1980		9:45 a.m.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH	
Female	White	February 21, 1897	83	Montgomery MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		Montgomery MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park	Sligo Gardens Nursing Home	Housewife	Home		
13a. STATE		13b. CITY OR TOWN	13c. STREET ADDRESS		
Maryland	20810	Laurel	15805 Sherwood Avenue		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
William Gilliss		Sarah Robinson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		212-40-6013		Robert W. Parks, Jr. Laurel, Md. 20810	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute pneumonitis					Two days
486- DUE TO, OR AS A CONSEQUENCE OF (b)					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
Generalized arteriosclerosis. Atrial fibrillation. Diabetes mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11 March 1976 to 23 March 1980, that (I) (we) last saw the deceased alive on 23 March 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE L.W. Malin		22c. DATE SIGNED 23 March 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
L.W. Malin, M.D./ C.J. Houmann, M.D.		4404 Queensbury Rd., Riverdale, Md. 20840			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		March 26, '80	Prospect Hill Cemetery	Baltimore County, Maryland	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
William E. Johnson		8521 Loch Raven Blvd.		MAR 26 1980	

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FOR
1- STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH07968
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Amos Patterson			2a. DATE KNOWN OF DEATH ESTI MATED <input checked="" type="checkbox"/> 3-11-1980 10 ⁰⁰ P M		
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 7 6 21 58 YRS.	6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 12 19 80 P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Realtor	
13a. STATE None		13b. CITY OR TOWN Wash D.C.		13c. STREET ADDRESS 3916 Legation St. N W.	
14. FATHER'S NAME FIRST MIDDLE LAST William J. Patterson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Hindeman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW 2 579-16-9588		17. INFORMANT ADDRESS Francis Patterson (Wife) 966-2457	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency Acute 411- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Cardio Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Chronic Alcoholism.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE John S. Ball		TITLE (SPECIFY) Deputy		DATE SIGNED March 12, 1980	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 3-13-80		23c. NAME OF CEMETERY OR CREMATORY Georgetown Med School	
24. FUNERAL DIRECTOR NAME Metropolitan Funeral Service, Alexandria, Va.		25a. DATE REC'D. BY REGISTRAR MAR 20 1980		25b. REGISTRAR'S SIGNATURE Anthony M. Brady	
23d. LOCATION CITY OR TOWN Washington, D.C.		STATE D.C.			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Washington D C

Department of the Interior

U S G S

General

Alexander V.

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Not to be used for any other purpose

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR			REG. NO.						
1 DECEASED NAME (TYPE OR PRINT) Ralph Lillington PAYNE			2a DATE OF DEATH March 25 1980				2b. HOUR 5:20P M		
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH August 28 1898		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U, S, Navy		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Maryland			13b COUNTY Montgomery		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET ADDRESS 2342 Glenmont Circle Apt. T-2		
14 FATHER'S NAME FIRST MIDDLE LAST William Payne			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Carson			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			
16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1917-47			17 INFORMANT Ralph E. Payne			17 ADDRESS S.C. 29577 704 Dogwood Ave, Myrtle Beach/			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peptic ulcer disease; small intestinal obstruction 5339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22 I certify that (h) (this hospital) attended the deceased from Mar. 1 1980 to Mar. 25 1980, that (i) (we) last saw the deceased alive on Mar. 25 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (h) (we) did (did not) view the body after death.									
22b SIGNATURE C. C. ELKINS, M.D.						DEGREE 2ND		22c. DATE SIGNED Mar. 27, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. C. ELKINS, M.D.						22e ADDRESS National Naval Medical Center, Bethesda, Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 3/28/80		23c NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va.			
24 FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home Rockville, Md.						25a. DATE REC'D. BY REGISTRAR APR 2 1980		25b. REGISTRAR'S SIGNATURE W. J. McCready	

15. 10. 1950

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Robert L Paxson Jr.

2a. DATE OF DEATH MONTH DAY YEAR
03-07-80

2b. HOUR

12:26 PM

3 SEX

M

4 RACE

W

5. DATE OF BIRTH

MONTH DAY YEAR
10 27 34

6. AGE (IN YEARS LAST BIRTHDAY)

45 YRS

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS DAYS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Washington, DC

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery

MD.

10. CITY OR TOWN OF DEATH

Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Holy Cross Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Planner

12b. KIND OF BUSINESS OR INDUSTRY

Bi-County

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE Maryland

13b. COUNTY Montgomery

13c. CITY OR TOWN Wheaton

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS

3613 Isbell St.

14. FATHER'S NAME

Robert

MIDDLE

L.

LAST

Paxson, Sr.

15. MOTHER'S MAIDEN NAME

Margaret

MIDDLE

LAST

Gormley

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

yes

16b. SOCIAL SECURITY NO

Korean 577-44-0375

17. INFORMANT (wife)

Betty A. Paxson-(same as 13e)

ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1629

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4/10/80

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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐ AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from Sept. 1978 to Mar. 7, 1980, that (I) (we) lost saw the deceased alive on Mar. 7, 1980 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Robert H. Grollman MD

22e. ADDRESS

1106 Silver Spring Ave., S.S. Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

3-11-1980

23c. NAME OF CEMETERY OR CREMATORY

Monacacy Cemetery Beallsville Montg. Md.

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR

Warner E. Pumphrey, Inc.

8434 Ga. Ave., S.S. Md.

25. DATE REC'D. BY REGISTRAR

MAR 13 1980

25b. REGISTRAR'S SIGNATURE

Robert H. Grollman



1. Name of the person: [illegible]
2. Date of birth: [illegible]
3. Place of birth: [illegible]
4. Occupation: [illegible]
5. Address: [illegible]
6. Telephone: [illegible]
7. Signature: [illegible]
8. Date: [illegible]
9. Remarks: [illegible]

[Handwritten signature]

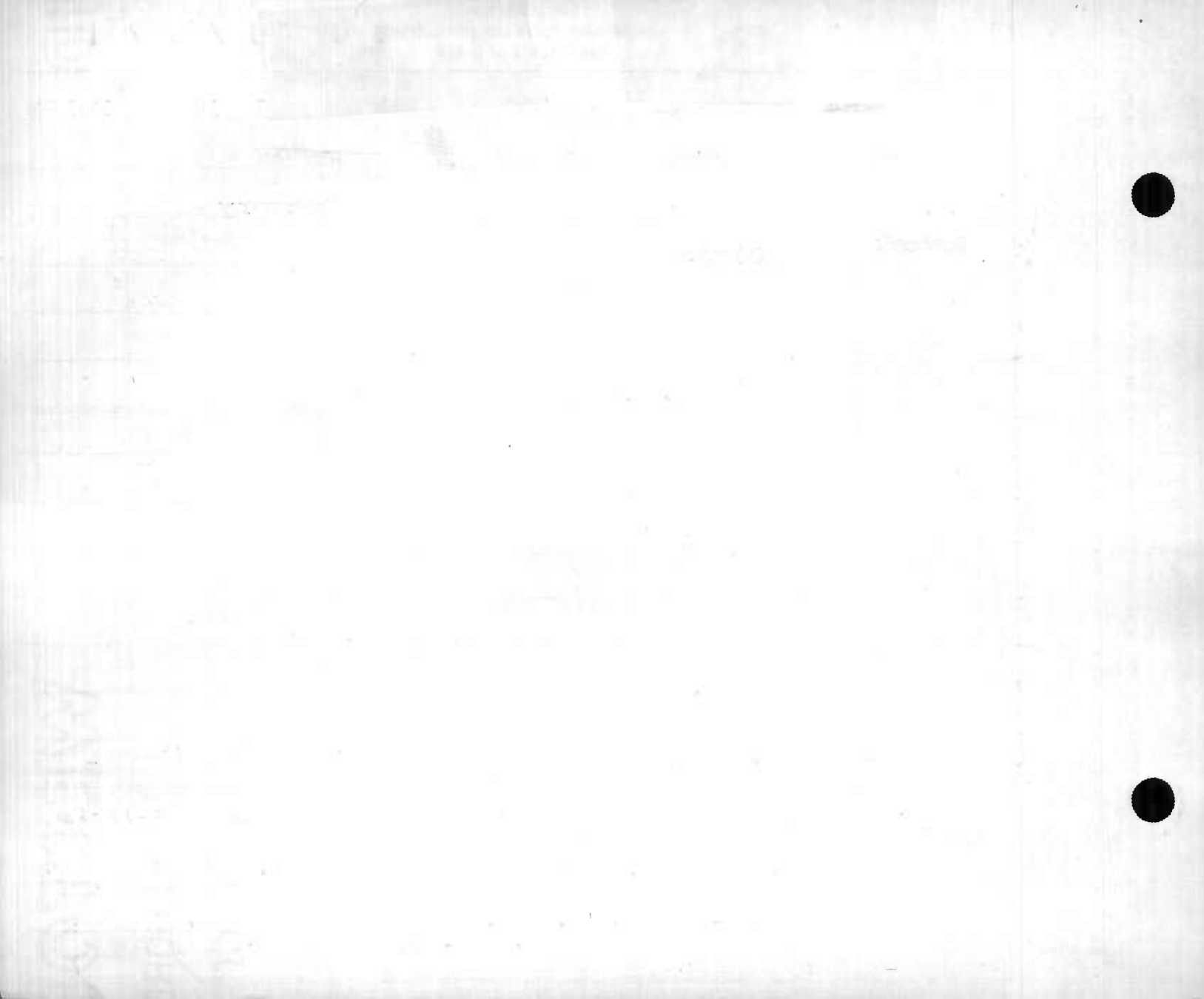
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 0 0 7 9 7 1									
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jack A. Peikin					3. SEX Male					4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 28 28		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		7. MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.					7b. CITIZEN OF WHAT COUNTRY? USA					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Bethesda					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner					12b. KIND OF BUSINESS OR INDUSTRY Furnace Install.				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS 10500 Rockville Pike							
13a. STATE Maryland					13b. COUNTY Montgomery					13c. CITY OR TOWN Rockville									
14. FATHER'S NAME FIRST MIDDLE LAST Barney Peikin					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Rose														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes					16b. SOCIAL SECURITY NO. Korea 579-28-8502					17. INFORMANT Helen Peikin; 10500 Rockville Pike					ADDRESS Rockville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour									
410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary heart disease</u>										3 months									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic arterial disease</u>										10 years									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes mellitus, peripheral vascular disease</u>																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from Dec. 19 56 to March 18 19 80, that (I) (we) last saw the deceased alive on Feb. 12 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE Arthur S. Bressler M.D.					DEGREE M.D.					22c. DATE SIGNED 3-18-80									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR S. BRESSLER, M.D.					22e. ADDRESS 10881 Lockwood Dr., Silver Spring, Md.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 3-20-80					23c. NAME OF CEMETERY OR CREMATORY Nat'l. Mem. Park					23d. LOCATION CITY OR TOWN FALLS CHURCH, VIRGINIA COUNTY STATE				
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike					ADDRESS Rockville, Md.					25a. DATE RECD. BY REGISTRAR MAR 21 1980					25b. REGISTRAR'S SIGNATURE [Signature]				



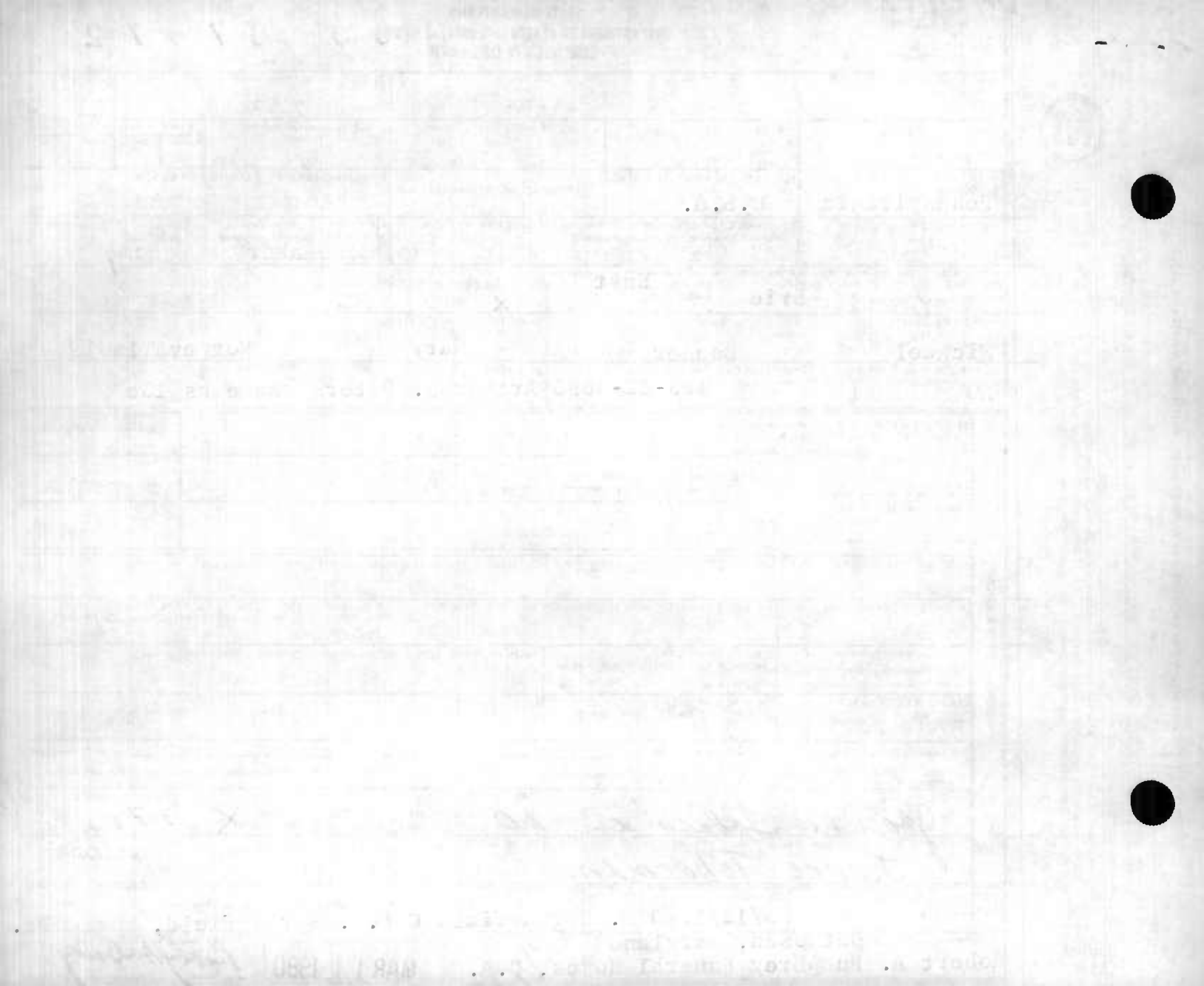
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Ruth Jean Peters						2a. DATE OF DEATH MONTH DAY YEAR March 7, 1980				2b. HOUR 11:45 ^{AM}			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 29, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.							
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, NIH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY home					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Pennsylvania						13b. COUNTY Erie		13c. CITY OR TOWN Springfield		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Michael Bender						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Not available							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 195-22-6693		17. INFORMANT ADDRESS Arthur N. Peters same as 13c									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate			
1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hepatic Failure</u>		2 months	
										DUE TO, OR AS A CONSEQUENCE OF (c) <u>Breast Cancer</u>		4 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>January 29, 1980</u> , to <u>March 7, 1980</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>March 7, 1980</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.													
22b. SIGNATURE <i>Joanne Tobacman</i>						DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-7-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joanne Tobacman						22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md							
23a. BURIAL, CREMATION, REMOVAL BURIAL				23b. DATE 3/12/1980		23c. NAME OF CEMETERY OR CREMATORY E. Springfield Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE E. Springfield Pa.				
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes, P.A.						25a. DATE REC'D. BY REGISTRAR MAR 11 1980		25b. REGISTRAR'S SIGNATURE <i>Barney M. Brady</i>					

BP.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

07973

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) AGNES			FIRST MIDDLE LAST Phillips			2a. DATE OF DEATH MONTH DAY YEAR 3/27/80			2b. HOUR 8 p M		
3 SEX Female			4 RACE White			5. DATE OF BIRTH MONTH DAY YEAR 7-25-92			6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ireland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Beth., Md.			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Saburpan Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Bethesda			13e. STREET ADDRESS 5006 Battery Lane		
14 FATHER'S NAME FIRST MIDDLE LAST Thomas Greelly						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bridget Henry					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No						16b. SOCIAL SECURITY NO. 215-50-7214			17. INFORMANT ADDRESS Margaret L. Phillips, Same as #13		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) probable ruptured ventricle 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) circule M.I. DUE TO, OR AS A CONSEQUENCE OF (c) ASCHD APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Cerebral emboli & infarction											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7/21 , 19 79 , to 3/27 , 19 80 , that (I) (we) last saw the deceased alive on 3/27 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John O. Allin M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3-28-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John O. Allin M.D.						22e. ADDRESS 8218 Wisconsin Ave. Bethesda Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/31/80			23c. NAME OF CEMETERY OR CREMATORY St. John's Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland		
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR APR 2 1980			25b. REGISTRAR'S SIGNATURE notary McBrady		

MEDICAL CERTIFICATION

29

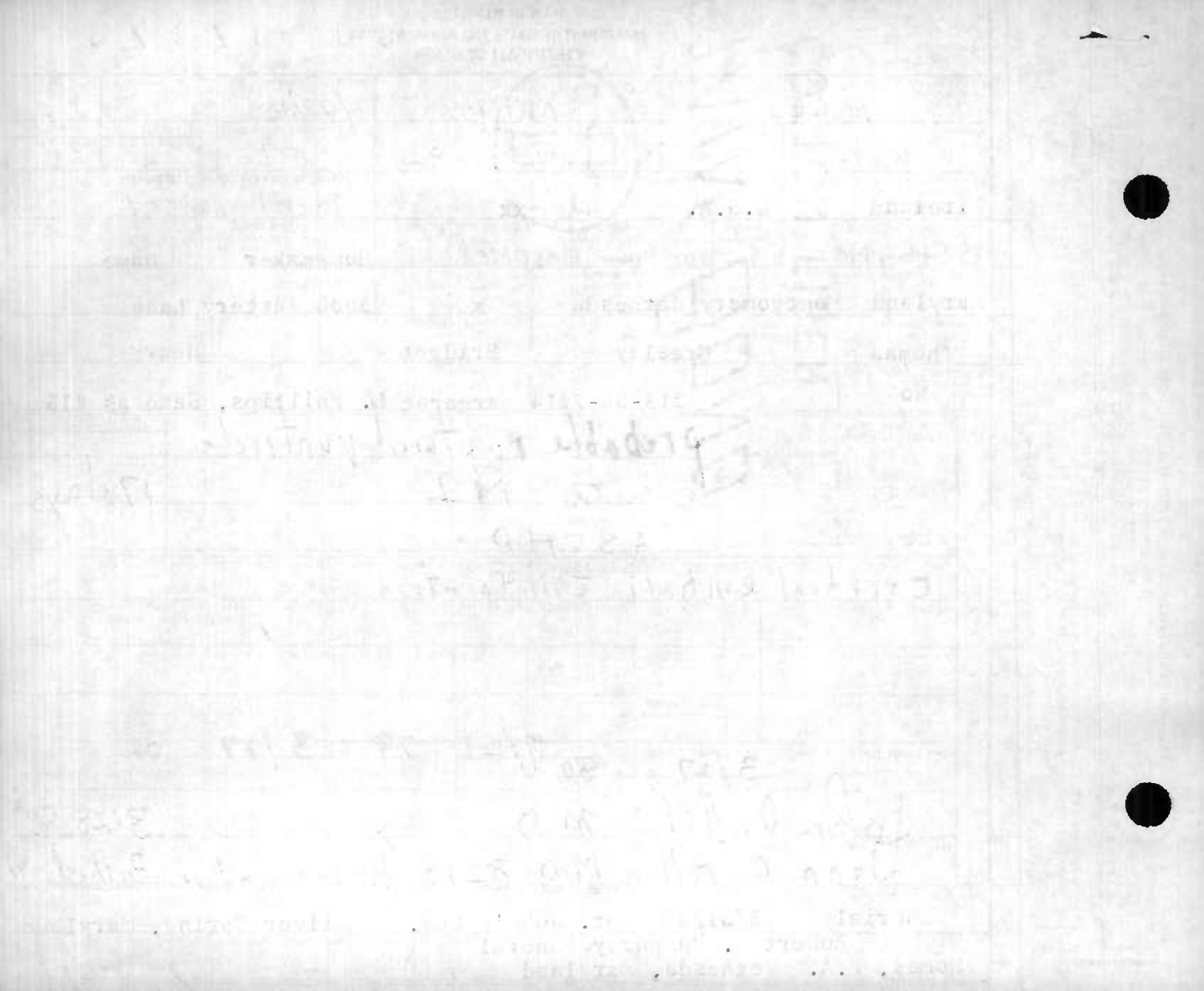
BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4801



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0007974					
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lyle W. Phillips				Mar. 31, 1980				4 PM M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Sept. 9, 1910		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. D.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) 4323 Leland St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physicist		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4323 Leland St.			
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase					
14 FATHER'S NAME FIRST MIDDLE LAST Reuben Phillips				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Rudd					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 134-07-8589		17 INFORMANT ADDRESS Martha L. Phillips Same as Item # 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Years.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3-31</u> 19 <u>80</u> to <u>3-31</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>3-31</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Irwin H. Ardam</u>				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3-31-80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Irwin H. Ardam, M.D.				22e. ADDRESS 5454 Wisc. Ave. Chevy Chase, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 4/1/80		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md.			
24 FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash., D.C.						25a. DATE REC'D. BY REGISTRAR APR 7 1980		25b. REGISTRAR'S SIGNATURE <u>Irving K. Brown</u>	

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FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO.

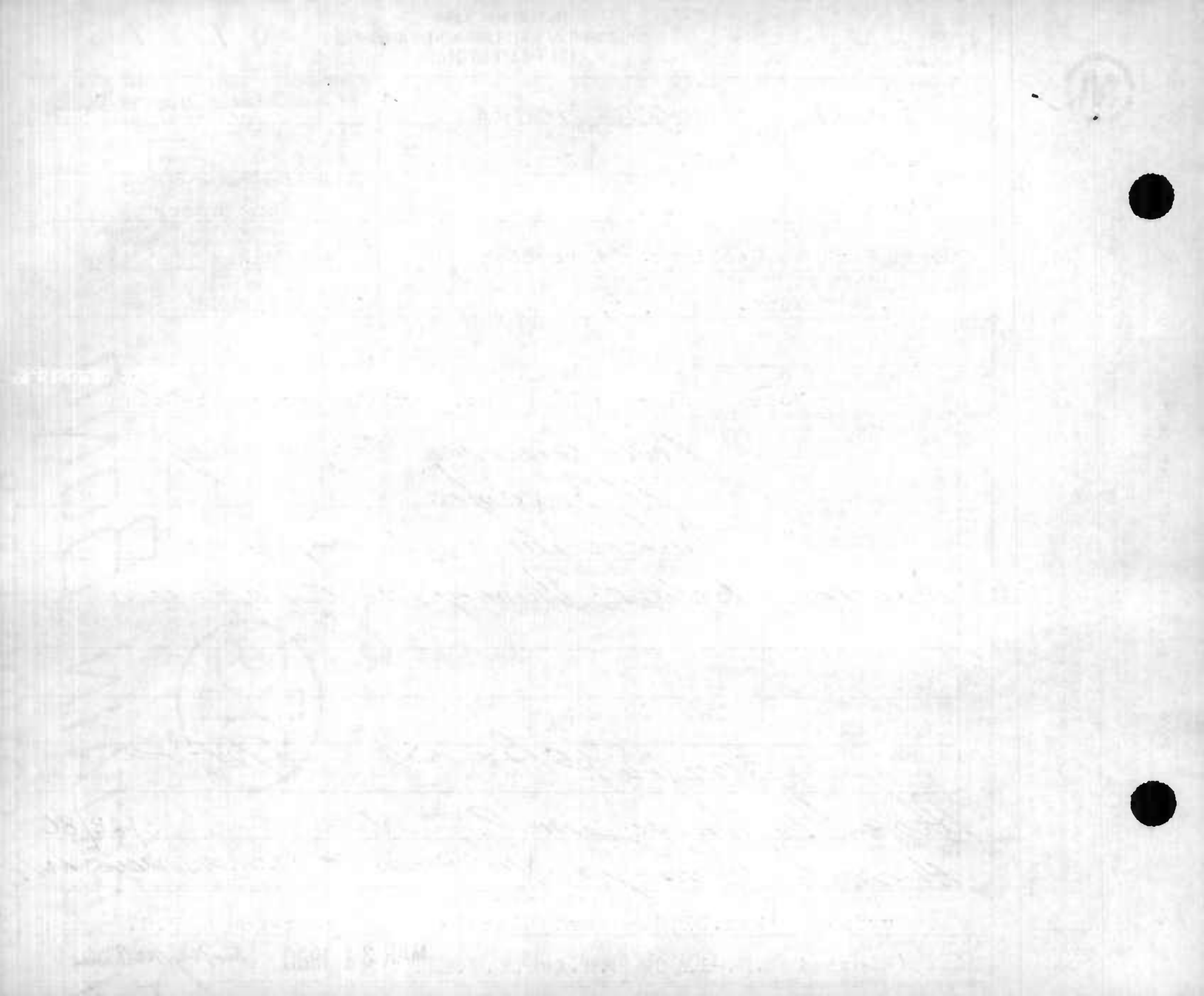
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1. DECEASED NAME (TYPE OR PRINT) Pearl Dawson Pierce			2a. DATE OF DEATH MONTH DAY YEAR 3-28-80		2b. HOUR 6:30 A.M.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 26 1899		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS None	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY None
13a. STATE Md.		13b. COUNTY Mont.	13c. CITY OR TOWN S. S.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Charles Dawson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Henrietta Bell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-07-2163B		17. INFORMANT ADDRESS 5369 Brook Way. Mrs. Neville Dorrycott-Columbia, Md.		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: b) Hypoxemia DUE TO, OR AS A CONSEQUENCE OF c) Pneumonia & Pulmonary Edema APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes Mellitus, Urinary Tract Infection						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 6/24 1976 to 3/28 1980 , that (I) (we) last saw the deceased alive on 3/27/80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) wear the body after death.						
22b. SIGNATURE Howard W. Kenney, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/28/80
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard W. Kenney, M.D.		22e. ADDRESS 1111 Spring St., Silver Spring, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 31, 80		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.-11800 N.H.Ave.S.S.Md.				25. DATE REC'D. BY REGISTRAR MAR 31 1980		25b. REGISTRAR'S SIGNATURE Henry McBrady

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1402



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0 0 7 9 7 6			
1. DECEASED NAME (TYPE OR PRINT) LOUIS		FIRST LOUIS		MIDDLE PISAPIA		LAST PISAPIA	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 14, 1902		6. AGE (IN YEARS (LAST BIRTHDAY)) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FOOD BROKER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ATTILIO PISAPIA		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARMEIA GALLONE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-20-0087	
17. INFORMANT ADDRESS MARGARET I. PISAPIA SAME AS 13 WIFE		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LEFT LOWER LOBE PNEUMONIA - VIRAL DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) SQUAMOUS CELL CARCINOMA OF BREAST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS? 8 MONTHS? 8 MONTHS +		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Diarrhea, dehydration, Anticoagulant heart disease with CHR. ATRIAL FIBRILLATION	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (1) (this hospital) attended the deceased from JAN 19 74 to MARCH 25 19 80 , that (2) (we) lost saw the deceased alive on MARCH 24 19 80 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did/did not) view the body after death.		22b. SIGNATURE John G. Nasou, MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED 3-25-80		22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN G. NASOU		22e. ADDRESS 800 BERSHING DRIVE SILVER SPRING, MD. 20910		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	
23b. DATE 3/28/80		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.		24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD., 20901	
25a. DATE REC'D. BY REGISTRAR MAR 26 1980		25b. REGISTRAR'S SIGNATURE John G. Nasou		25c. REGISTRAR'S NAME John G. Nasou		25d. REGISTRAR'S ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD., 20901	

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RECEIVED
JAN 10 1964
U.S. AIR FORCE
AIR MAIL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked ☒ shows any injury, or other traumatic event, the medical examiner must be notified.

RELEASED BY MEDICAL EXAMINER DR. BALL 3-18-80

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO. 07977		2a DATE OF DEATH		MONTH DAY YEAR		2b HOUR	
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a DATE OF DEATH		MONTH DAY YEAR		2b HOUR	
SHIRLEY		PLANGGER		March 18, 1980				9:00 am	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR	
Female		Caucasian		Aug 14, 1898		81 YRS.		MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Russia		USA				Montgomery			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Rockville		6111 Montrose Road, Apt. 726		Business Woman		Automotive			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?	
Maryland		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
Nathan		Brokofsky		Beckie		Raulstein		Silver Spring, Md.	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		17 ADDRESS		Silver Spring, Md.	
No		041-14-9893D		Harry Brokofsky;		3301 So. Leisure World Blvd.			
11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary arrest</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u>	
4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u>								years	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterio-vascular disease</u>								years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION		CITY OR TOWN		COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET					
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED	
Dr. Samuel Goldberg				X				3-18-80	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS		22f DATE REC'D. BY REGISTRAR		22g REGISTRAR'S SIGNATURE			
Dr. Samuel Goldberg		11125 Rockville Pike, #309, Rockville, Md.		MAR 21 1980		H. J. McCreedy			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION		COUNTY STATE	
Burial		3-20-80		Judean Memorial Gardens		Olney, Montg., Md.			
24 FUNERAL DIRECTOR NAME		ADDRESS		24b DATE REC'D. BY REGISTRAR		24c REGISTRAR'S SIGNATURE			
DANZANSKY-GOLDBERG MEM. CHAP.		Rockville, Md.		MAR 21 1980		H. J. McCreedy			



Chronic
Lung
Disease

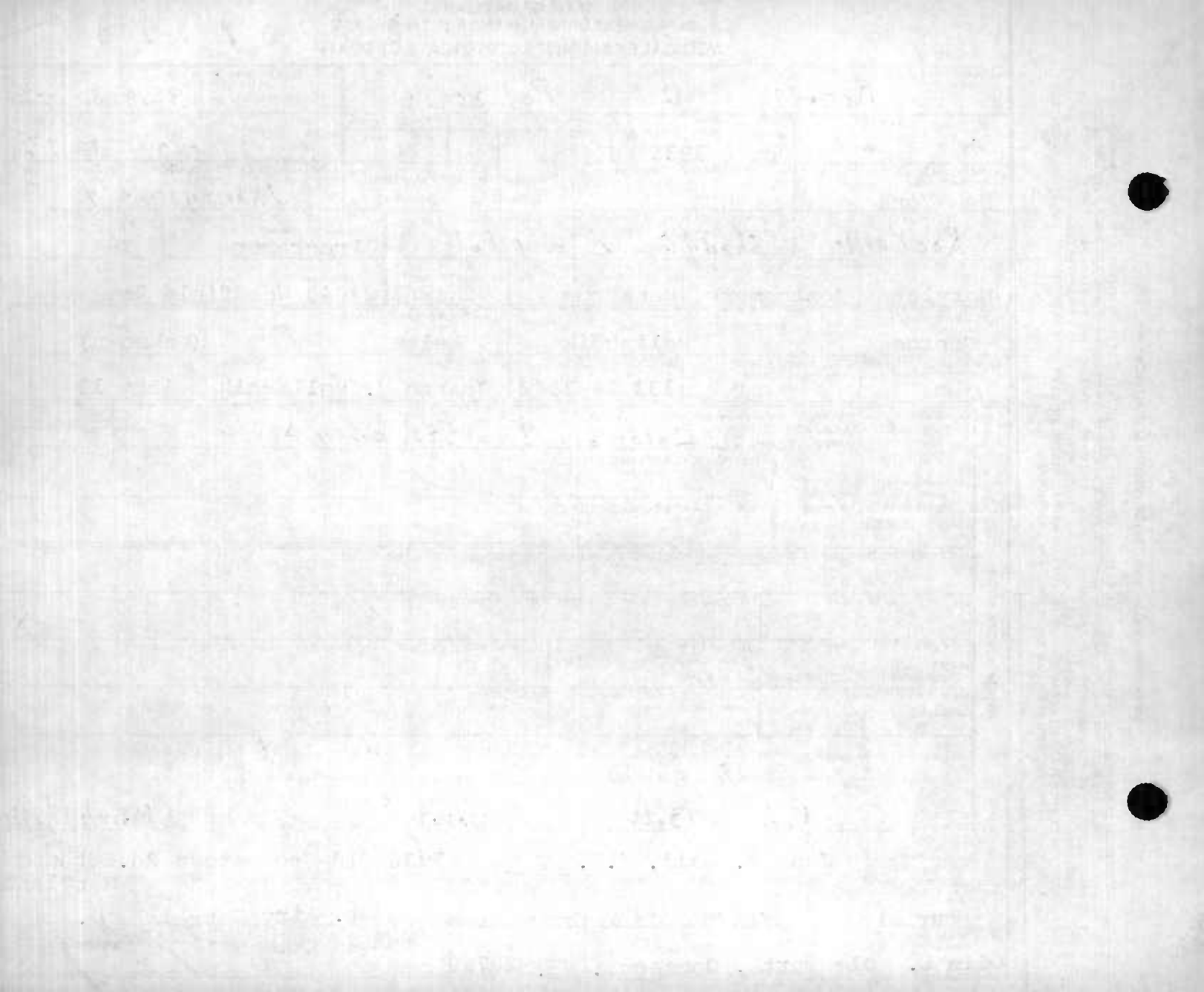
12 months
from
onset

3-18-80 X *[Signature]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE ALIAS EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										07978 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST Robert		MIDDLE G.		LAST Poliachik		2a. DATE KNOWN OF DEATH ESTIMATED		<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 3-19-80 7:45 PM	
3. SEX M.	4. RACE W.	5. DATE OF BIRTH MONTH DAY YEAR Oct 6 1935		6. AGE (IN YEARS) LAST BIRTHDAY 44 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD March 19 1980		2d. HOUR 7:45 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Programmer		12b. KIND OF BUSINESS OR INDUSTRY IBM			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Damascus		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 24848 Woodfield Road			
14. FATHER'S NAME FIRST MIDDLE LAST George Poliachik				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen (Unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 133 24 2842		17. INFORMANT ADDRESS Jeanne M. Poliachik item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> 411- Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED March 19, 1980			
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D.				ADDRESS 7936 Old Georgetown Rd. Bethesda Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/22/80		23c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Airy Carroll H.			
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, Damascus, Md., 20750				25a. DATED BY REGISTRAR MAR 21 1980				25b. REGISTRAR'S SIGNATURE [Signature]			



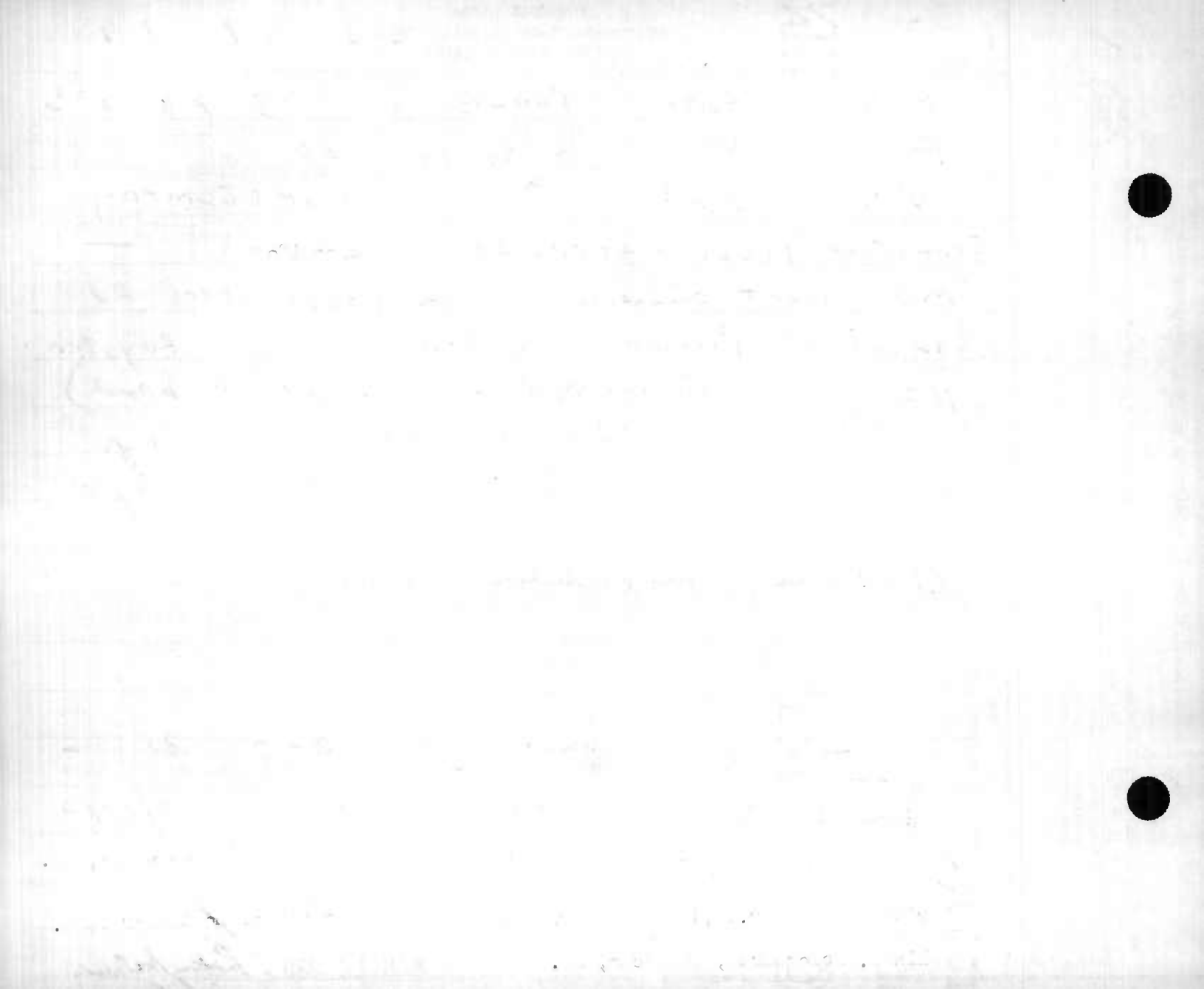
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 07979	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mildred Edith POOLE				2a. DATE OF DEATH MONTH DAY YEAR 3 7 80		2b. HOUR 8:25 P.M.		
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 7 21 19		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH German-Town		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 19621 WATERS RD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY MONT		13c. CITY OR TOWN German-Town		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 19621 WATERS RD			
14. FATHER'S NAME FIRST MIDDLE LAST J. Samuel Pearson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie E. Royster							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-74-4591		17. INFORMANT ADDRESS MARTIN POOLE (Husband)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMATOSIS 1749 DUE TO, OR AS A CONSEQUENCE OF (b) Ca of Breast DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr 3 yrs											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Cancer, malnutrition, Bone Fracture											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from June 19 77, to 3-7 19 80, that (I) (we) last saw the deceased alive on Feb 18 19 80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)											
22b. SIGNATURE John S. Saia				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/8/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John S. Saia				22e. ADDRESS 809 Vicis Mill Rd Rockville, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 10, 1980		23c. NAME OF CEMETERY OR CREMATORY Parklawn		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Montgomery, Md.					
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, Damascus, Md. ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE F. J. Kelly			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

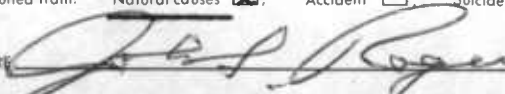

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 07980			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) CHARLES EBEN PREBLE Sr				2b. HOUR 0744A M			
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR AUGUST 16, 1999		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAT'L NAVAL MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE VIRGINIA				13b. COUNTY FAIRFAX		13c. CITY OR TOWN ANNANDALE	
14. FATHER'S NAME FIRST MIDDLE LAST HERBERT PREBLE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY (last name unknown) PREBLE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 013-05-2036		17. INFORMANT ADDRESS SON, 8027 GARLOT DR. ANNANDALE, VA.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ADENOCARCINOMA OF PANCREAS 1579 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I (this hospital) attended the deceased from 15 FEBRUARY, 19 80 to 15 MARCH, 19 80, that I (we) lost saw the deceased alive on 15 MARCH, 19 80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.							
22b. SIGNATURE Kenneth E. Oswalt, MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 15 MARCH 80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENNETH E. OSWALT M.D.				22e. ADDRESS 19425 Brassie Pl., Apt 303, Gaithersburg, MD			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 3/18/1980		23c. NAME OF CEMETERY OR CREMATORY HOLY CROSS		23d. LOCATION CITY OR TOWN COUNTY STATE MALDEN MASS.	
24. FUNERAL DIRECTOR NAME John W. D. Demaine				25. DATE REC'D. BY REGISTRAR MAR 19 1980		25b. REGISTRAR'S SIGNATURE [Signature]	
24. FUNERAL DIRECTOR ADDRESS Demaine Funeral Homes, Inc. Alexandria, Va.							

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(last page of manuscript)

The well known of 1740

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR		STATE OF MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH				07981 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frederick FRED Robert Prentiss						2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 19 3/24 19 80				2b. HOUR M 4:20 P. 4:20			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 10, 1896		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS 83 84		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 19 3/24 19 80		7d. HOUR M 4:20 P. 4:20			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Hampshire				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9401 Colesville Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Ins.				12b. KIND OF BUSINESS OR INDUSTRY State Farm	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9401 Colesville Road					
14. FATHER'S NAME FIRST MIDDLE LAST Fred Prentiss						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (unknown) Roberts							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 212-14-1240		17. INFORMANT (son) ADDRESS Box., 157 Robert W. Prentiss-Broomes Island, Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial disease. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Diabetes mellitus													
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER 1919 Seminary Road Silver Spring, Montgomery, Md.				DATE SIGNED 3/24/80	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3-26-80		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Georges Md.			
24. FUNERAL DIRECTOR NAME Ernest E. Pumphrey, Inc.				ADDRESS 8434 Ga. Ave., S.S. Md.				25a. DATE REC'D. BY REGISTRAR MAR 28 1980				25b. REGISTRAR'S SIGNATURE 	

White Pine Co. 11, 1912-13
X
Mont. Gen. Court

Silver Spring 1911
Mont. Gen. Court
Silver Spring 1911
X
Mont. Gen. Court

Mont. Gen. Court
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 0 0 7 9 8 2							
1. DECEASED NAME (TYPE OR PRINT) ANNIE M QUINN			2a. DATE OF DEATH 3 01 80			2b. HOUR 4 30 P M			
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH AUG 12 1887		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IRELAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEKEEPER		12b. KIND OF BUSINESS OR INDUSTRY Private Employer	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE		13b. COUNTY		13c. CITY OR TOWN WASH. D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5437 CONN AVE. N.W.	
14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL - QUINN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE ANNIE - McMAHON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 579-22-0617		17. INFORMANT NEICE ANASTASIA O'ROURKE		ADDRESS SAME AS #13			
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). ACUTE PULMONARY EDEMA 4292 DUE TO, OR AS A CONSEQUENCE OF (b). CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c). ARTERIOSCLECTIC CARDIOVASCULAR DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hour 3 Hours 8 YEARS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). ACUTE BRONCHITIS									
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSE OF DEATH? YES <input type="checkbox"/> N/A, NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A,					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> N/A		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A					
22a. I certify that (I) (this hospital) attended the deceased from August 19 76 to March 1st 19 80, that (I) (we) lost saw the deceased alive on March 1st 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE Dennis J. Hand MD				DEGREE		22c. DATE SIGNED 3/1/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DENNIS J. HAND MD				22e. ADDRESS 4600 CONNECTICUT AVE. N.W. - WASHINGTON D.C.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-5-80		23c. NAME OF CEMETERY OR CREMATORY ST. PATRICKS CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE LOWELL MASS			
24. FUNERAL DIRECTOR NAME Robert A. DeVos				ADDRESS WASH. D.C. 2222 Wix Ave.		25. DATE REC'D. BY REGISTRAR MAR 7 1980		25b. REGISTRAR'S SIGNATURE [Signature]	

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 0 0 7 9 8 3

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Arthur Edward Quinn			2a. DATE OF DEATH MONTH DAY YEAR 3/9/80		2b. HOUR 12³⁰ AM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR SEPT 6, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) COLORADO	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOOKBINDER	12b. KIND OF BUSINESS OR INDUSTRY GPO	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN WHEATON	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3207 PAUL DRIVE	
14. FATHER'S NAME FIRST MIDDLE LAST PATRICK FRANCIS QUINN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY DROHAM		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 521-09-8505		17. INFORMANT ADDRESS ADA M. QUINN SAME AS 13 WIFE	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1629 CARCINOMA OF LUNG DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 weeks					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 2/24 , 19 80 , to 3/9 , 19 80 , that (I) (we) lost saw the deceased alive on 3/9 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Kirkland C. Bease			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/10/80
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kirkland C. Bease			22e. ADDRESS 4600 CARROLL AVE TAKOMA PARK, MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 3/12/80	23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS			25a. DATE REC'D. BY REGISTRAR MAR 10 1980		
25b. FUNERAL HOME 500 UNIV BLVD. W. SILVER SPRING, MD. 20901			25c. REGISTRAR'S SIGNATURE Richard McBrady		

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession be retained by the hospital or attending physician.

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500 1014 BLVD. W. SILVER SPRING MD. 20901
 FRANCIS J. COLLINS
 F151A
 FT. LINCOLN DISTRICT
 BETHWOOD
 FBI GED MD

NO 221-22-2202 ADA H. GUYAN CASE IS 12 DATE

PATRICK FRANCIS GUYAN JURY

WASHINGTON MONTGOMERY WHEATON KY 2202 FALL BRIDE

TAYLOR PARK WASHINGTON WHEATON MONTGOMERY KY

COLORED U.S.A. MONTGOMERY

SENT 2 1967

FILE 221-22-2202

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WILMA			2a. DATE OF DEATH MONTH 3 DAY 18 YEAR 80			2b. HOUR 4:45 PM			
3 SEX Female		4 RACE white		5 DATE OF BIRTH MONTH Sept DAY 10 YEAR 1891		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS		7 UNDER 1 YEAR MONTHS 0 DAYS 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Finland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Saleswoman		12b. KIND OF BUSINESS OR INDUSTRY Dept Store	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Takoma Pk, Md.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST Eric Johnson MIDDLE LAST 			15. MOTHER'S MAIDEN NAME FIRST Milna Numelin MIDDLE LAST 			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 541-20-2570A			17. INFORMANT Terrace Bethesda, Md. 20014			18. ADDRESS Laura K. Seeborg-daughter 10102 Parkwood			
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4149 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Malnutrition ; Depression									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 12/6 19 79 , to 3/18 19 80 , that (we) last saw the deceased alive on 3/18 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Norman H. Rubenstein			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/18/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Norman H. Rubenstein, M.D.			22e. ADDRESS White Oak Prof. Bldg.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 3-20-80		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. 20002		
24. FUNERAL DIRECTOR NAME Lee Funeral Home			ADDRESS 300-4th St. N.E. Wash. D.C. 20002			25a. DATE REC'D. BY REGISTRAR 6 MAR 21 1980		25b. REGISTRAR'S SIGNATURE notary McCreedy	

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELEANOR L. RAVILIOUS			2a. DATE OF DEATH MONTH DAY YEAR March 20 80		2b. HOUR 11:58am		
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR AUG. 23 1900		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ROCKVILLE NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED GARMENT		12b. KIND OF BUSINESS OR INDUSTRY WORKER	
13a. STATE DELAWARE		13b. COUNTY NEW CASTLE		13c. CITY OR TOWN WILMINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES Shupe		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Aurelia Pauley		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 195-14-7988	
17. INFORMANT ADDRESS MARGARET E. COOPER, 602 Hummingbird Way Prescott, Arizona		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary failure</u> 436- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arteriosclerotic heart disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <u>8-10-</u> 19 <u>77</u> , to <u>3-20</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>3-12</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22c. DATE SIGNED 3-21-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KWANG S. KIM		22e. ADDRESS 615 W. Montgomery Ave. Rockville, MD		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/24/80	
23c. NAME OF CEMETERY OR CREMATORY Gracelawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington Delaware		24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. 300 W. Montgomery Ave., Rockville, MD		25a. DATE REC'D. BY REGISTRAR MAR 28 1980	
25b. YEAR'S SIGNATURE R. A. Pumphrey		25c. SIGNATURE R. A. Pumphrey		25d. SIGNATURE R. A. Pumphrey		25e. SIGNATURE R. A. Pumphrey	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages must be retained by the hospital or attending physician.

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195-14-7300



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195-14-7300

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Robert A. Brown, General Counsel, P.A.
200 N. Montgomery Ave., Knoxville, TN 37902

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 07986	
1- FOR STATE REGISTRAR						2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)						3/24/80		3:37P			
FIRST		MIDDLE		LAST							
SIDNEY		H.		REAMER							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.	
MALE		WHITE		Jan 9 14 68		YRS.		MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
MARYLAND		U.S.A.		WIDOWED		DIVORCED		Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Takoma Park		Washington Adventist Hospital		PHARMACIST		DRUG STORE					
13a. STATE						13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.						Mont		Bt. Pk.		YES X	
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME					
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST	
JACOB				REAMER		DORA				BERKOW	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO						212-07-8437		ERIC M. DRATTELL		18534 BAY LEAF WAY, GERMANTOWN, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u>											
4291 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) <u>Chronic Myocardial Dis.</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
<u>None</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
<u>None</u>								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION			
								STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE				TITLE (SPECIFY)				MEDICAL EXAMINER			
<u>John S. Rogers</u>				M.D. <u>Deputy</u>				<u>March 24 1980</u>			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
DR. JOHN S. ROGERS				1919 SEMINARY ROAD, SILVER SPRING, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
BURIAL				3/25/1980		MOUNT LEBANON CEMETERY		ADELPHI, PR. GEORGES, MARYLAND			
24. DONOR'S NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
DONALD M. STEIN				MAR 27 1980				<u>History Kebody</u>			
26. ADDRESS											
232 CARROLL STREET, N. W., WASHINGTON, D. C.											

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Information for inventors

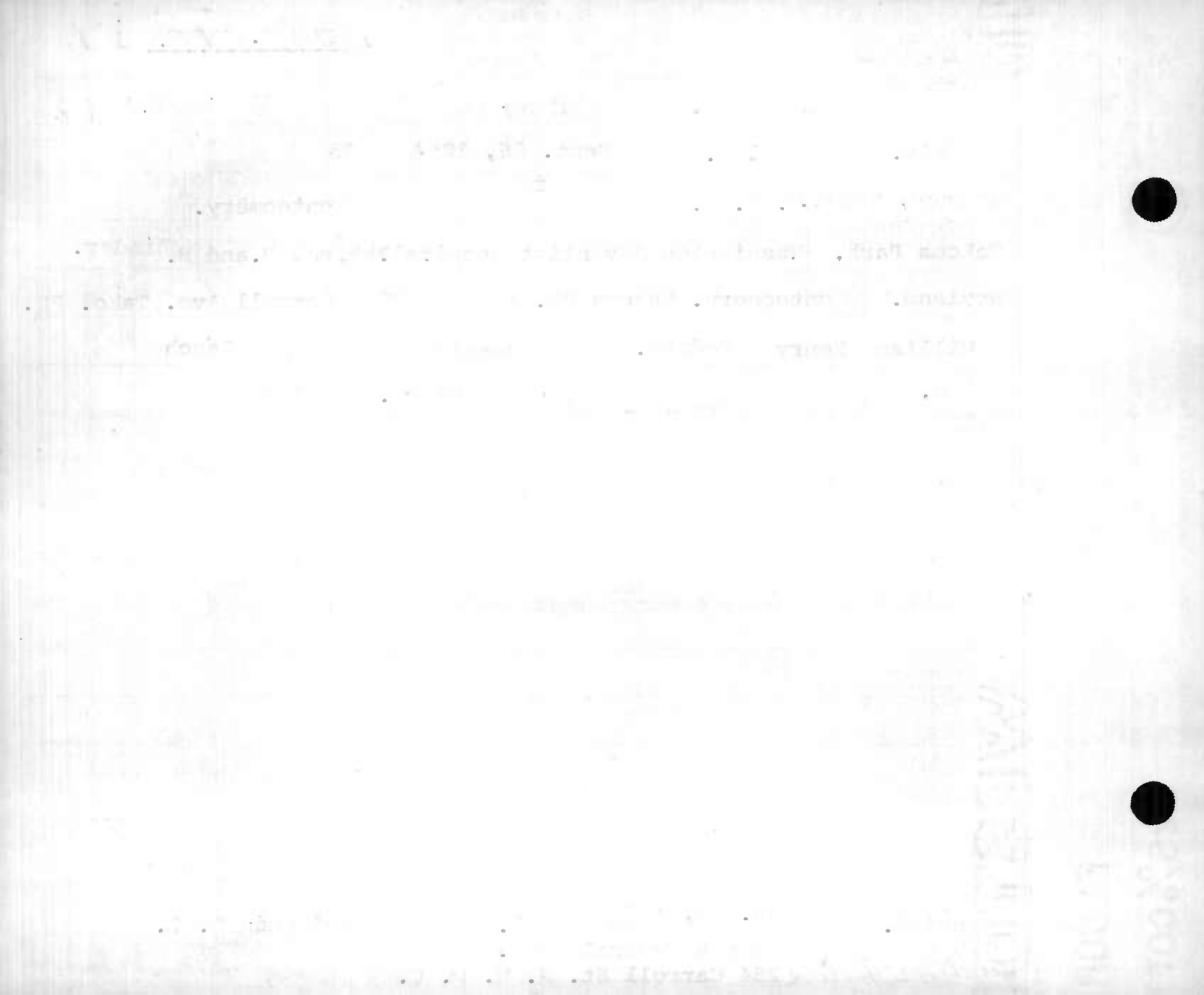
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										LEON H. REDMAN	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		DAY		YEAR	
LEON H. REDMAN			3		22		1980		1 P.M.		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
Male.			White.			Sept. 18, 1894			85		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Lebanon, Penna.			U. S. A.						Montgomery. MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park.			Washington Adventist Hospital			Retired R. and H. Binder.					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland.			Montgomery.			Takoma Park			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NAME (UNKNOWN) (IF YES, GIVE WAR OR DATES))			16b. SOCIAL SECURITY NO.		
William Henry Redman.			Jennie Rauch			NO.			020-34-8594		
17. INFORMANT			18. ADDRESS			19. DATE OF OPERATION			20. CONDITION FOR WHICH OPERATION WAS PERFORMED		
Ruth Redman.			13 e								
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cordic Pulmonary Arrest</u> 436- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pericardial vascular accident</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u> <u>+ 24 hr.</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Parkinson's, myeloma - Chronic Sinus syndrome. Osteoporosis - Asymptomatic Prostate.</u>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			22a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			22b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 3</u> , 19 <u>77</u> , to <u>March 22</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>March 22</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Hugo B. Graziani</u>			22c. DEGREE <u>MD</u>			22d. DATE SIGNED <u>3-22-80</u>			22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HUGO B. GRAZIANI</u>			22g. ADDRESS <u>802 Park St. S.S. Md. 20910</u>			22h. DATE REC'D. BY REGISTRAR			22i. REGISTRAR'S SIGNATURE <u>Robert McCreedy</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial.</u>			23b. DATE <u>Mar. 25, 1980</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek.</u>			23d. LOCATION CITY OR TOWN COUNTY STATE <u>Washington D. C.</u>		
24. FUNERAL DIRECTOR <u>Robert Walters</u>			25a. DATE REC'D. BY REGISTRAR <u>MAR 26 1980</u>			25b. REGISTRAR'S SIGNATURE <u>Robert McCreedy</u>			25c. ADDRESS <u>254 Carroll St. N. W. D.</u>		



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 0 7 9 8 8

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARY BERLIN REED		2a. DATE OF DEATH MONTH DAY YEAR MARCH 5 1980		2b. HOUR 2:30PM	
3. SEX Female	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 7 - 9 - 93		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH OLNEY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Brooke Grove Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher-Retired		12b. KIND OF BUSINESS OR INDUSTRY D.C. Schools
13a. STATE MD		13b. COUNTY WASH. D.C.	13c. CITY OR TOWN WASH. D.C.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1819 37th Street, N.W.
14. FATHER'S NAME FIRST MIDDLE LAST Allen P. Berlin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Abigail I. Gardner		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 090 24 8816		17. INFORMANT ADDRESS 934 Columbian Ave Katharine Port/Neice/ Oak Park, Ill.	
18. CAUSE OF DEATH Enter only one cause per line for (1), (2), and (3). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Lung Disease 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Impaired Ventilation (c) Obstructive Pulmonary Disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Organic Brain Syndrome					
19a. DATE OF OPERATION 2/9		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Chronic Lung Disease		19c. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE 1819 P. Phily Dr Arlington Virginia	
22. I certify that (1) (this hospital) attended the deceased from above, (2) (we) (did) (not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
23a. SIGNATURE CHL		DEGREE		23c. DATE SIGNED 3/5/80	
23b. PHYSICIAN'S NAME (TYPE OR PRINT) CHL		23d. ADDRESS 1819 P. Phily Dr Arlington Virginia		23e. DATE REC'D. BY REGISTRAR MAR 10 1980	
23f. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23g. DATE Mar. 7 1980		23h. NAME OF CEMETERY OR CREMATORY Arlington National Cem	
23i. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia		23j. NAME OF CEMETERY OR CREMATORY Arlington National Cem		23k. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia	
24. FUNERAL DIRECTOR NAME DeVol Funeral Home		24b. ADDRESS 2222 Wisc, Ave. Washington D.C.		24c. DATE REC'D. BY REGISTRAR MAR 10 1980	
24d. REGISTRAR'S SIGNATURE Robert A. DeVol		24e. REGISTRAR'S SIGNATURE Robert A. DeVol		24f. REGISTRAR'S SIGNATURE Robert A. DeVol	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0 0 7 9 8 9			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST 13001087 , ROSCOE REEVES				2a. DATE OF DEATH MONTH DAY YEAR 3 2 80			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT 30, 1888		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BROOKE GROVE NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARTOGRAPHIC SECTION GEOLOGICAL		12b. KIND OF BUSINESS OR INDUSTRY U.S.	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN N. CHEVY CHASE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN WESLEY REEVES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLEMENZA MAY		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 220-44-0209	
17. INFORMANT SON		ADDRESS 3706 INVERNESS DR.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic pulmonary obstructive disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Chronic pulmonary obstructive disease</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>4:30</u> 19 <u>80</u> , to <u>present</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>4:30</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE <u>John B. Umhau</u>				DEGREE <u>M.D.</u>		22c. DATE SIGNED 3/2/80	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John B. Umhau</u>				22d. ADDRESS 8805 Conn. Ave. Chevy Chase, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/6/80		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR MAR 1 1980		25b. REGISTERED <u>John B. Umhau</u>	
500 UNIV. BLVD., W., SILVER SPRING, MD., 20901							

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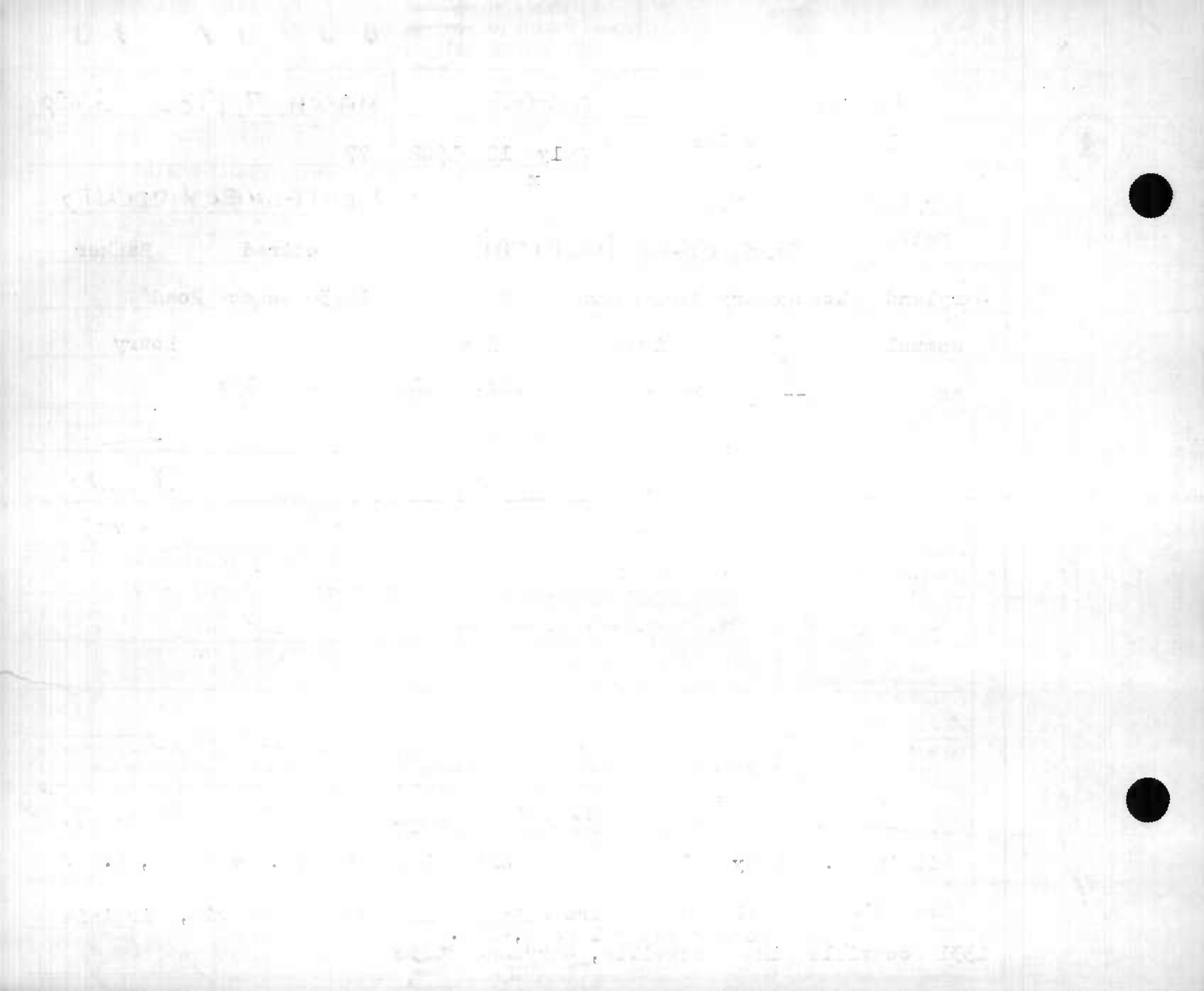
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 0 0 7 9 9 0						
1. DECEASED NAME (TYPE OR PRINT) REUBEN			FIRST MIDDLE LAST RIGGS			2a. DATE OF DEATH MONTH DAY YEAR MARCH 7, 1980		2b. HOUR 3:45 PM	
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR July 12 1902		6. AGE (IN YEARS LAST BIRTHDAY) 77		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Banker	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Germantown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 14530 Seneca Road	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Riggs			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Lowry						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO 216 14 3965			17. INFORMANT ADDRESS Dirck Teller same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Aneurysm 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) Severe Bradycardia DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 10 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION (GIVE IN PART I): Cholesterol, Coronary Heart Disease, Paroxysmal Atrial Fibrillation, Hypertension, Diabetes Mellitus, Arteriosclerosis									
19a. DATE OF OPERATION 4 March 80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pericardial Ablation				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from March 1, 1978 to March 7, 1980 , that (I) (we) last saw the deceased alive on March 7, 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE William H. Killay			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED March 7, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William H. Killay			22e. ADDRESS 8218 Wisconsin Ave. Bethesda, Md 20014						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/13/80		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc.				25. DATE REC'D. BY REGISTRAR 17 1980		25b. REGISTRAR'S SIGNATURE Henry McBrady			
24b. ADDRESS 1351 Rockville Pike Rockville, Maryland 20852									



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 0 0 7 9 9 1

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Annie L. Risher			2a. DATE OF DEATH MONTH DAY YEAR 3 24 80			2b. HOUR 2 05 A	
3. SEX F		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPT. 26 1890		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISS.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) COLLINGSWOOD NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SINER ST.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT R. GREENE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIA OPORTON		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) UNKNOWN	
17. INFORMANT DOAN R. MORENO		ADDRESS 4005 DUNDRA KENSINGTON MD		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PANCREAS DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) 1579		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	

MEDICAL CERTIFICATION

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

1) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE WITH C.V.A.

19a. DATE OF OPERATION MARCH 27 1979		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA OF PANCREAS		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from January 19 75 to March 19 80, that (I) (we) last saw the deceased alive on March 24 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE Charles David Spencer MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/27/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles David Spencer MD				22e. ADDRESS 10500 SUMMIT AVE, KENSINGTON, MD.			

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE 3/31/1980		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY COUNTY STATE ROCKVILLE MD	
24. FUNERAL DIRECTOR NAME John R. Risher		ADDRESS 5500 FR BLVD		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 1 1980			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, pages 3 and 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 07992			
1. FOR STATE REGISTRAR			2a. DATE OF DEATH		MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ernest Jerome Robinson			3-22-80		2b. HOUR 3:10 PM			
3. SEX Male		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR Dec. 9 1899		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. Adventist Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired U.S. Govt		12b. KIND OF BUSINESS OR INDUSTRY MACINTOSH		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2401 Westwind DRIVE			
14. FATHER'S NAME FIRST MIDDLE LAST Jerome B Robinson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Loeffler					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None			16b. SOCIAL SECURITY NO. 579-16-8429		17. INFORMANT ADDRESS Elsie P. Robinson 2401 Westwind Drive Silver Spring, Md.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Mesenteric Thrombosis						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
5570 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis						2 DAYS		
DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Bladder								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Arteriosclerosis								
19a. DATE OF OPERATION 3-11-80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Bladder			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from May 1st, 1980 to May 22, 1980, that (I) (we) lost saw the deceased alive on May 22, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Joseph Bloom			DEGREE			22c. DATE SIGNED 3/22/1980		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Bloom			22e. ADDRESS 1111 Spring St. Silver Spring Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 25 MAR 1980		23c. NAME OF CEMETERY OR CREMATORY 7th Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Bladensburg Md.		
24. FUNERAL DIRECTOR NAME Wm. R. Smith 11800 N.H. Ave			ADDRESS Silver Spring Md.		DATE REC'D. BY REGISTRAR MAR 27 1980		25b. REGISTRAR'S SIGNATURE Kristy McCreedy	

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CHICAGO, ILL. 60637

DATE
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					REG. NO. 8 0 0 7 9 9 3				
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT HARRY ROBINSON					2a. DATE OF DEATH MONTH DAY YEAR March 10, 1980			2b. HOUR 3:10AM	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR April 19, 1925		6 AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		7 UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, Bethesda, MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SETTER		12b. KIND OF BUSINESS OR INDUSTRY SHIRTS	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 802 Braeside Rd 21229	
14 FATHER'S NAME FIRST MIDDLE LAST ROBERT ROBINSON					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTRUDE BOSTON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 212-20-8875		17 INFORMANT ADDRESS (same as above) Mrs. Rose Marie Robinson (wife)					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interstitial pulmonary fibrosis</u> 4280 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary infarcts, multiple</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive heart failure</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 3</u> 19 <u>80</u> to <u>March 10</u> 19 <u>80</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>March 10</u> 19 <u>80</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (I) (did) (not) view the body after death.									
22b. SIGNATURE Rita M Watson MD					DEGREE		22c. DATE SIGNED 3-10-80		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>
22e. PHYSICIAN'S NAME (TYPE OR PRINT) RITA M WATSON MD					22f. ADDRESS National Institutes of Health Clinical Center, Bethesda, MD 20205				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3-13-80		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		23d. LOCATION CITY OR TOWN COUNTY STATE BETHESDA MD		
24 FUNERAL DIRECTOR NAME ADDRESS WEBER FUNERAL HOME EDMONDSON					25a. DATE REC'D. BY REGISTRAR MAR 12 1980		25b. REGISTRAR'S SIGNATURE Rita M Watson		

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C.

Per U.S. A.S.M. 1914
No. 1000

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WASHINGTON, D.C.

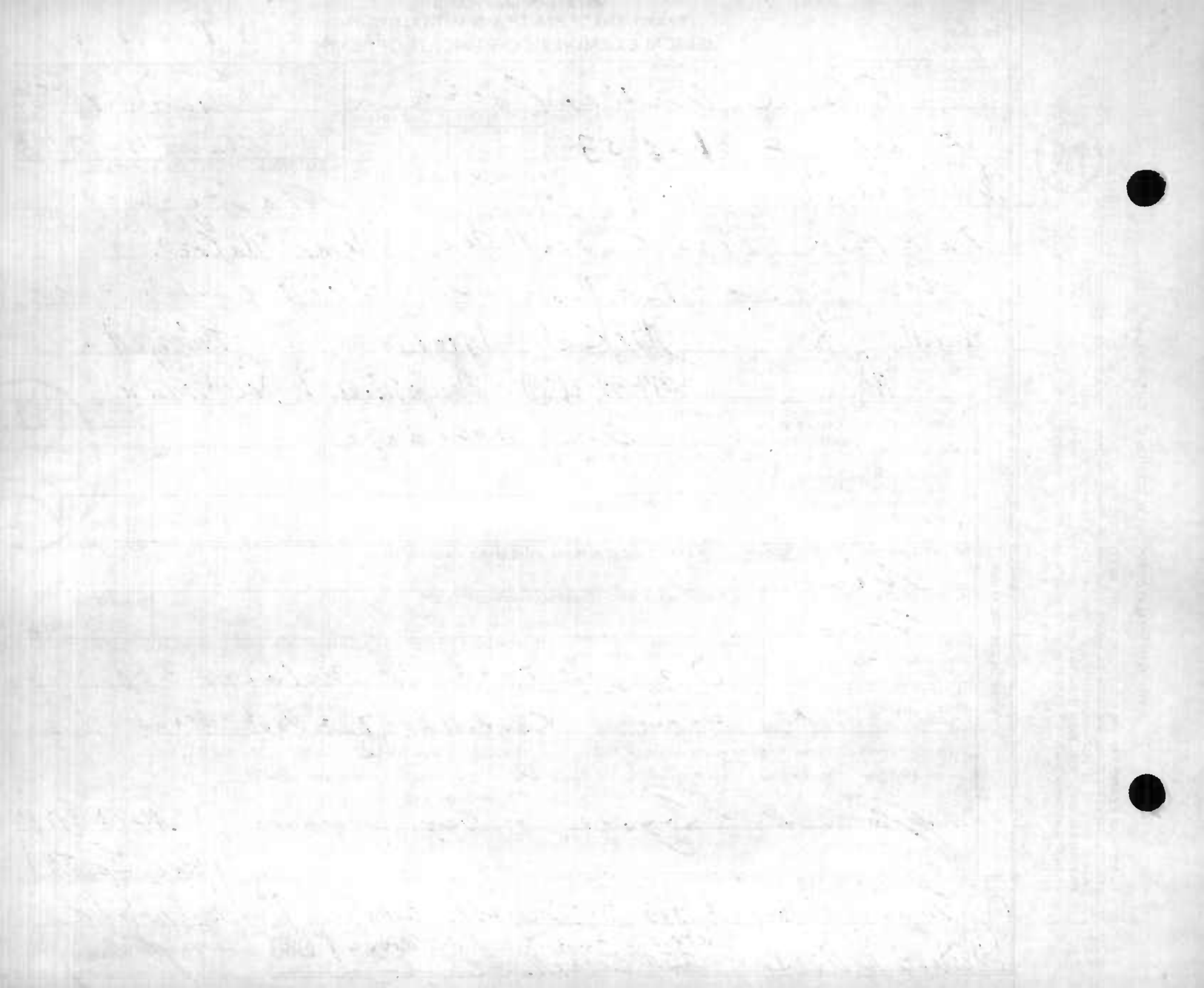
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WASHINGTON, D.C.

PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 WITH VITAL FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL FILES AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										07994 REG. NO.																													
1. DECEASED NAME (TYPE OR PRINT)										FIRST MIDDLE LAST										2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR OF ESTI-MATED DEATH																									
Elaine Walker Rockman																				March 13, 1980		4:30 PM																											
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR																																
F		W		March 31, 1953			53		MONTHS DAYS		HOURS MIN		March 13, 1980				4:30 PM																																
7a. BIRTHPLACE (COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH																											
Washington D.C.										U.S.A.												Montgomery MD.																											
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY																											
Tak Park										2105 Carroll Ave										Home Maker																													
13a. STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS									
MD										Mont										Tak Park										YES										2105 Carroll Ave									
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																							
First MIDDLE LAST										First MIDDLE LAST																																							
Russell K. Walker										James Trizzell																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)										16b. SOCIAL SECURITY NO.										17. INFORMANT										ADDRESS																			
No										517-32-6683										Benjamin W. Rockman																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART I DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
9502										IMMEDIATE CAUSE (a) Drug Overdose																																							
										DUE TO, OR AS A CONSEQUENCE OF																																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										(b)										DUE TO, OR AS A CONSEQUENCE OF																													
																				(c)																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																																	
None																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																													
None																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																													
										P.M. 3/12/80										rock 18 Volvular 308																													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION																													
										Home										Carroll Ave, Tak Park Mont MD																													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																																																	
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED																													
[Signature]										M.D. [Signature]										March 13/1980																													
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION																			
Burial										March 14, 1980										St. Elizabeth's Cemetery										Tak Park, Montgomery Co, MD																			
24. FUNERAL DIRECTOR (NAME)										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
Arthur Walters										25/4/1980										[Signature]																													



Items 5, 6, 8, 542 4/1/80 gj

FOR
1- STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07995
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Clara</i>		MIDDLE <i>C.</i>		LAST <i>Rodriguez</i>		2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> 3/9 1980		2b. HOUR M A					
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH (MONTH DAY YRS.) <i>Mar. 22, 1909</i>		6. AGE (IN YEARS) (MONTH DAY YRS.) <i>79</i>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD <i>3/9 1980</i>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County</i> MD.									
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>1400 Fenwick Lane, #703</i>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE <i>Maryland</i>				13b. COUNTY <i>Montgomery</i>				13c. CITY OR TOWN <i>Silver Spring</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Un/k Cornett</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>U/k</i>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <i>1400 Fenwick Lane, #703</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES/NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>None</i>				17. INFORMANT NAME ADDRESS <i>Grace Roberge, 8404 Flower Ave Takoma Park, Md 20012</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. <i>4029</i> (b) <i>hypertensive heart disease.</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Upper respiratory infection</i>															
19a. DATE OF OPERATION <i>None</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>None</i>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <i>Natural causes</i> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <i>John S. Rogers, M.D.</i>				TITLE (SPECIFY) <i>Deputy</i>				MEDICAL EXAMINER DATE SIGNED <i>3/9/80</i> <i>Montgomery, Md.</i>							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS <i>1919 Seminary Rd., Silver Spring</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>				23b. DATE <i>Mar. 10, 1980</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory Suitland P.G.</i>							
24. FUNERAL DIRECTOR NAME ADDRESS <i>W.W. Chambers 8655 Ga. Ave. Sil. Spgs. Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>MAR 14 1980</i>				25b. REGISTRAR'S SIGNATURE <i>Barney McCready</i>							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

00 07996

1. DECEASED NAME (TYPE OR PRINT) PERCY R. ROGERS			2a. DATE OF DEATH MONTH DAY YEAR 3 12 80			2b. HOUR 8:10 P.M.					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 11 92		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH Wheaton Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wheaton Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CPA		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10012 PORTLAND PLACE		
14. FATHER'S NAME FIRST MIDDLE LAST Michael W. ROGERS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY Jane HENRY				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		17. INFORMANT MARY JANE RUBIN	
18a. SOCIAL SECURITY NO. 577-03-1781				18b. SOCIAL SECURITY NO. 577-03-1781				18c. SOCIAL SECURITY NO. 577-03-1781			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of lung with metastases DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 80 10 28			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			21g. DATE SIGNED 3/13/80		
22a. I certify that (I) (this hospital) attended the deceased from 3/12 19 80 , to 3/12 19 80 , that (I) (we) last saw the deceased alive on 3/12 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (did not) see the body after death.											
22b. SIGNATURE Myron L. Lenkin						DEGREE PHYSICIAN			22c. DATE SIGNED 3/13/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MYRON L. LENKIN						22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3/15/80			23c. NAME OF CEMETERY OR CREMATORY PARKLAWN			23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONTGOMERY MD.		
24. FUNERAL DIRECTOR'S NAME FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR MAR 17 1980			25b. REGISTRAR'S SIGNATURE Anthony McCreedy		
26. ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											

MEDICAL CERTIFICATION

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WESTBURY, MD

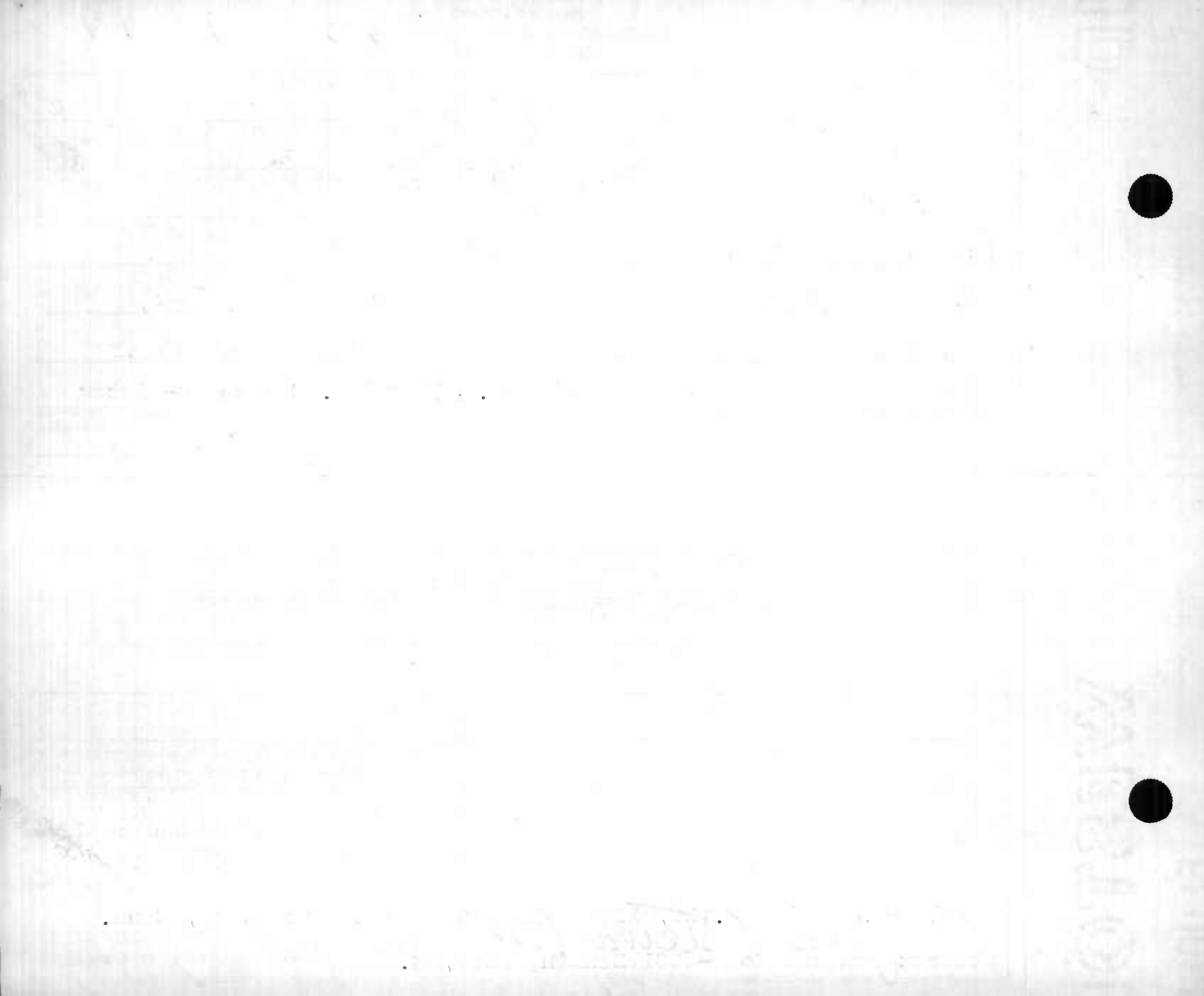
WESTBURY, MD

WESTBURY

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>ELIZABETH ROSCOE</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3/22/80</i>			2b. HOUR AM PM <i>2:30 AM</i>					
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2/4/08</i>		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <i>72</i>		7. IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN <i>72</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Spain</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Mont</i> MD.					
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist</i>		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <i>MD. P.G. Adelphi</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>1801 Margaret Rd.</i>							
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles W. Roscoe</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Nellie M. Prince</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>no</i>							
16b. SOCIAL SECURITY NO. <i>040 24 3431</i>		17. INFORMANT NAME ADDRESS <i>Mrs. Mildred R. Carethers-sister</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>terminal renal failure, AHD, old MI</i> 2500 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Diabetes mellitus</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Septicemia</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>years</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>1978</i> , 19____, to <i>1980</i> , 19____, that (I) (we) last saw the deceased alive on <i>3/21/80</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>[Signature]</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3/22/80</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>CSOTH LERAGUE MD</i>		22e. ADDRESS <i>7425 arlington Rd, Bethesda MD</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial-Removal</i>		23b. DATE <i>Mar. 29, 1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Old Pine Grove</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Waterbury, Conn.</i>					
24. FUNERAL DIRECTOR NAME <i>Stewart</i>		25a. DECEASED BY REGISTRAR <i>APR 1 1980</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							





STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

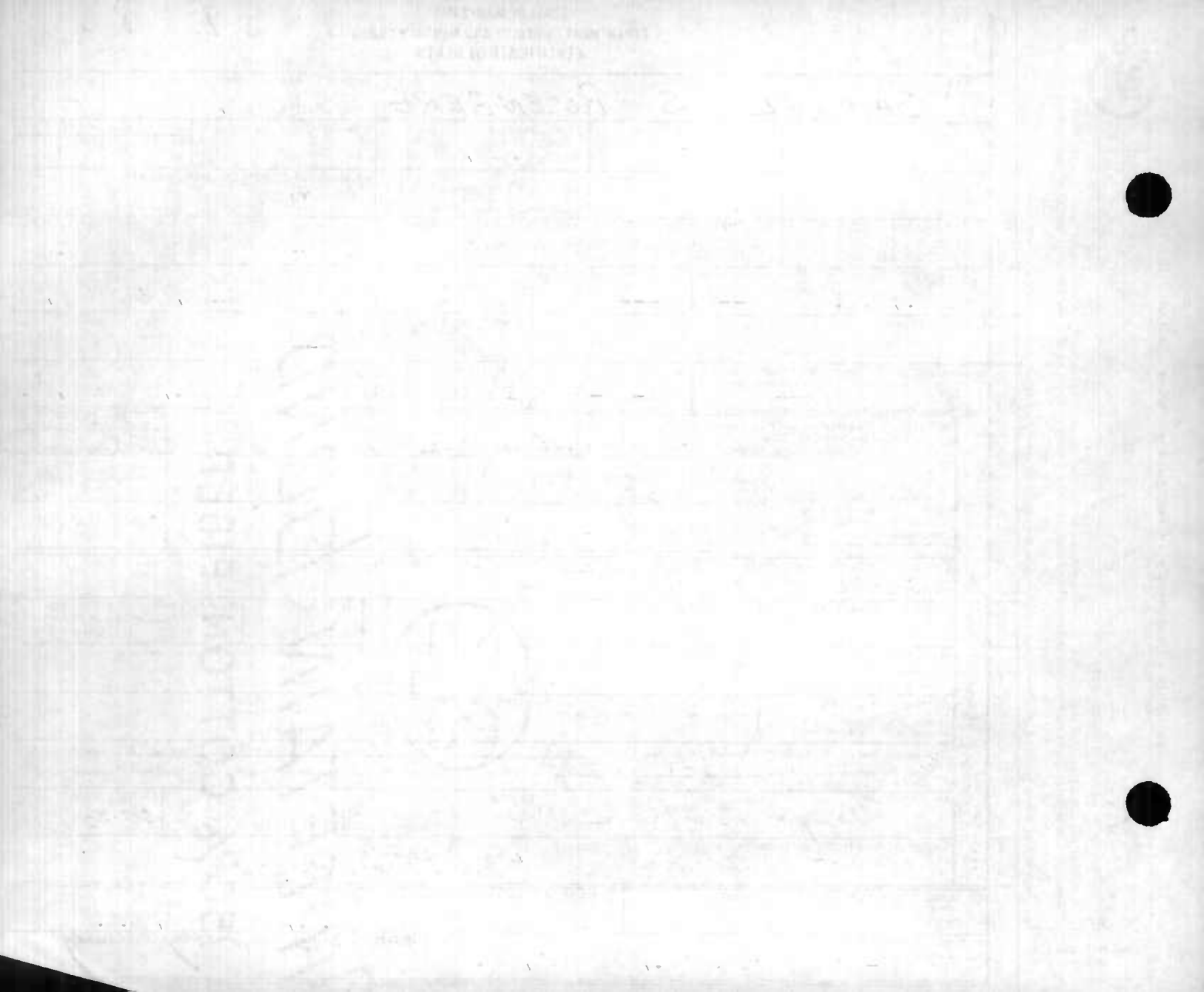
1. DECEASED NAME (TYPE OR PRINT) SAMUEL S ROSENBERG			2a. DATE OF DEATH MONTH DAY YEAR MARCH 7, 1980			2b. HOUR 2:50 P.M.			
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR NOV. 22, 1896		6 AGE (IN YEARS LAST BIRTHDAY) 83		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FERNWOOD NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OWNER-OFFICE FURNITURE CO.			
13a. STATE WASH., D.C.			13b. COUNTY --		13c. CITY OR TOWN ---		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST JACOB AARON ROSENBERG					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE --- GOLDSTEIN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 578-48-3184		17 INFORMANT ADDRESS INA LORBER (DAU) 6523 ELGIN LA., BETHESDA, MD.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial degeneration 5829 DUE TO, OR AS A CONSEQUENCE OF (b) Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Chronic renal insufficiency								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days - over 30 days over 30 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Ischemic bowel disease									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 19 3-7 , 19 80 , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Wyrth Post Baker MD DEGREE					ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3-7-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WYRTH POST BAKER MD					22e. ADDRESS 4701 WILLARD AVE CITRUS CITY MD 20015				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 3/10/80		23c. NAME OF CEMETERY OR CREMATORY ADAS ISRAEL		23d. LOCATION CITY OR TOWN COUNTY STATE S.E. WASHINGTON, D.C.		
24 FUNERAL DIRECTOR DANZANSKY-GOLDBERG MEM. CHAP., ROCKVILLE, MD.					25. DATE OF BURIAL MAR 18 1980				

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION
checked by Medical Examiner

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) SARAH ROSENFELD					2a. DATE OF DEATH 3 10 80			2b. HOUR 8 ³⁰ A M		
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH JULY 15, 1896		6 AGE (IN YEARS LAST BIRTHDAY) 83		7. IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD				
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPER. AT LINGERIE MANUFACTURING		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND					13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME ISAAC GOLDBERG					15. MOTHER'S MAIDEN NAME ROSE TAIASHOFF					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 068-07-9981		17. INFORMANT ADDRESS IRVING GOLDBERG (NEPHEW) SAME AS ABOVE						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Subarachnoid Hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic Heart Disease</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from <i>3/10/80</i> to <i>3/10/80</i> , that (1) (me) last saw the deceased alive on <i>3/10/80</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (me) (did not) view the body after death.										
22b. SIGNATURE <i>Blaine Fitzgerald</i>					22c. DEGREE M.D.		22d. DATE SIGNED 3/10/80		22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22f. PHYSICIAN'S NAME (TYPE OR PRINT) J. Blaine Fitzgerald M.D.					22g. ADDRESS 8218 Wisc. Ave. Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/12/80		23c. NAME OF CEMETERY OR CREMATORY KING SOLOMON		23d. LOCATION CITY OR TOWN COUNTY STATE CLINTON NEW JERSEY		23e. DATE REC'D. BY REGISTRAR MAR 17 1980		
24. FUNERAL DIRECTOR DANZANSKY-GOLDBERG MEM. CHAP. ROCKVILLE, MD.										
25a. REGISTRAR'S SIGNATURE <i>Pitney McCreedy</i>										

10

James M. Smith
Census Bureau

James M. Smith
Census Bureau

James M. Smith
Census Bureau

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Inez Clair Ross					2a DATE OF DEATH MONTH DAY YEAR March 26 1980			2b HOUR 8 A M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR July 2 1889		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10 CITY OR TOWN OF DEATH S.S.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY 13c CITY OR TOWN Md PG Beltsville					13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 11457 Cherry Hill Rd.		
14 FATHER'S NAME FIRST MIDDLE LAST Benjamin Hargrave					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth McNeil				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None		16b SOCIAL SECURITY NO 177 03 9842		17 INFORMANT Same as above ADDRESS 2D Thelma Spadaro (Daughter)					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Vasc. Accident</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Mononucleosis</i>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 10 YEARS		21f LOCATION STREET CITY OR TOWN COUNTY STATE Mar 26 19 80					
22a. I certify that (I) (this hospital) attended the deceased from <i>Mar 25</i> 19 <i>80</i> , to <i>Mar 26</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>Mar 25</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we did not) view the body after death.									
22b SIGNATURE <i>Robert Kramer</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c DATE SIGNED <i>3/26/80</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Robert Kramer					22e ADDRESS 8630 FENTON ST. SIL 8P6ND				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 3/29/80		23c NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Norfolk, Va.			
24 FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.					24b ADDRESS 11800 N.H.Ave.S.S.Md.				

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DHM-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Terri Marie Rowan			2a. DATE OF DEATH MONTH DAY YEAR March 13, 1980			2b. HOUR 6:20 P.M.			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 04/12/1965		6 AGE (IN YEARS LAST BIRTHDAY) 14		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Clinical Center, NIH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. STATE New York		13b. COUNTY Orange		13c. CITY OR TOWN Sparrow Bush		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Hagen Road 12780	
14 FATHER'S NAME FIRST MIDDLE LAST John Rowan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Davis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (GIVES GIVE WAR OR DATES) None		17 INFORMANT ADDRESS Mrs. Catherine Davis, Same					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Pulmonary Hemorrhage 7473 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF S/P Conduit bypass, right ventricle to right pulmonary artery (c) Pulmonary atresia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION 3/13/1980			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (he/she) attended the deceased from 9 March 1980 to 13 March 1980 , that (we) last saw the deceased alive on 13 March 1980 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE Karl J. Karlson, MD						DEGREE MD		22c. DATE SIGNED 3/14/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KARL J. KARLSON, MD						22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md			
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial			23b. DATE Mar. 17, 80		23c. NAME OF CEMETERY OR CREMATORY Beemerville		23d. LOCATION CITY OR TOWN COUNTY STATE Beemerville, Sussex, N.J.		
24 FUNERAL DIRECTOR NAME W.W. Chambers, 8655 Georgia Ave, Sil. Spgs.						25a. DATE OF REGISTRATION MAR 16 1980		25b. REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)		FIRST Jessie V.		MIDDLE RUSSELL		LAST L		2a. DATE OF DEATH		MONTH MAR		DAY 13		YEAR '80		2b HOUR 2:30		M	
3 SEX FEMALE		4 RACE Caucasian		5. DATE OF BIRTH		MONTH June		DAY 20		YEAR 1880		6 AGE (IN YEARS (LAST BIRTHDAY)) 99		YRS		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.													
10 CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson Health Care Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Landlady, Bd. House		12b KIND OF BUSINESS OR INDUSTRY Rental													
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.		13b COUNTY Arundel		13c CITY OR TOWN Annapolis		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 156 Prince George St.											
14 FATHER'S NAME FIRST Jessie		MIDDLE J.		LAST Russell		15 MOTHER'S MAIDEN NAME FIRST Virginia		MIDDLE -		LAST Kane		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES) No							
16b SOCIAL SECURITY NO. 213-50-7206		17 INFORMANT (Records) Asbury Meth. Home		201 Russell Ave., Gaithersburg, Md.															
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 4870 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Influenza</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 week</u> <u>10 days</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE															
22a I certify that (1) <u>this hospital</u> attended the deceased from <u>Nov 75</u> to <u>3/13/80</u> , that (1) <u>we</u> last saw the deceased alive on <u>3/13/80</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, and (2) <u>we</u> did not view the body after death.																			
22b SIGNATURE <u>Thos G. Ward</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>																			
22c DATE SIGNED 3/13/80																			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 3/17/'80		23c NAME OF CEMETERY OR CREMATORY St. Anne's Cemetery		23d LOCATION CITY OR TOWN Annapolis		COUNTY Arundel		STATE Md.									
24 FUNERAL DIRECTOR <u>Gartner-Sandison</u>		316 E. Diamond Ave.		25a DATE REC'D. BY REGISTRAR MAR 20 1980		25b REGISTRAR'S SIGNATURE <u>History McCready</u>													

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

1913
No. 1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 08003	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) NELL L. Dixon Russell						2a. DATE OF DEATH MONTH DAY YEAR MAR 12 '80		2b. HOUR 6:30 P.M.	
3. SEX FEMALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 2, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Germantown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 18517 Kingshill Road			
14. FATHER'S NAME FIRST MIDDLE LAST Immanuel Jackson Dixon				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Mae Garriss							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 238-05-5956		17. INFORMANT ADDRESS Mr. James L. Russell Same as 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Influenza</u> (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 1 WEEK	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>3/11/80</u> to <u>3/12/80</u> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Thos G. Ward		22c. DATE SIGNED 3/13/80		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. Ward							
22e. ADDRESS 116 Robinwood Rd Bethesda, Md 20814											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3-13-80		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia		23e. DATE OF RECORD MAR 19 1980			
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., Bethesda, Maryland											

10

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO. 08004					
1. DECEASED NAME (TYPE OR PRINT) Spencer S Russell					2a. DATE OF DEATH MONTH DAY YEAR March 12 80					2b. HOUR 7:00 P M
3 SEX male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Apr. 30 1919		6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel-Pre Health Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY None		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2601 Bel Pre Road		
14 FATHER'S NAME FIRST MIDDLE LAST Percy H. Russell					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tuna V. Saunders					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17 INFORMANT ADDRESS Falls Church, Va. Mrs. Henry Rachlin-6306 Beachway Dr.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Respiratory failure										3 days
DUE TO, OR AS A CONSEQUENCE OF (b) Bronchitis										one week
DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema										1 year.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 6-4-79 to 3-12-80 , that (I) (we) last saw the deceased alive on 3-11-80 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Michael R. DeBridge					DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED March 12, 1980		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael R. DeBridge					22e. ADDRESS 13975 Conn. av. Silver Spring Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar. 18, 80		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Wash. D.C.		
24 FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.					ADDRESS -11800 NH Ave. S.S. Md.			25a. DATE REC'D. BY REGISTRAR MAR 15 1980 25b. REGISTRAR'S SIGNATURE Jeffrey M. Brady		

178990-0

CONFIDENTIAL

CONFIDENTIAL

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0 0 8 0 0 5				
1. DECEASED NAME (TYPE OR PRINT) Wendy Kay Salm				2a. DATE OF DEATH MONTH DAY YEAR March 6, 1980				2b. HOUR 9:00 A
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR August 25, 1965		6 AGE (IN YEARS LAST BIRTHDAY) 14 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois	7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10 CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, Bethesda, Md.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY School		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Illinois				13b. COUNTY Iroquois		13c. CITY OR TOWN Martinton		
14. FATHER'S NAME FIRST MIDDLE LAST Wendell H. Salm				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sandra Castognia				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 331-66-0663		17. INFORMANT ADDRESS (same as above) Mr. Wendell H. Salm, Father				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 1991 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic osteogenic sarcoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 mos.								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>February 26, 1980</u> , to <u>March 6, 1980</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>March 6, 1980</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.								
22b. SIGNATURE <u>Robert T. Maguire</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/06/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT T. MAGUIRE				22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md. 20205				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/10/80		23c. NAME OF CEMETERY OR CREMATORY Oak Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Watseka, Iroquois, Ill.		
24. FUNERAL DIRECTOR NAME W. Chambers Co.-Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR MAR 13 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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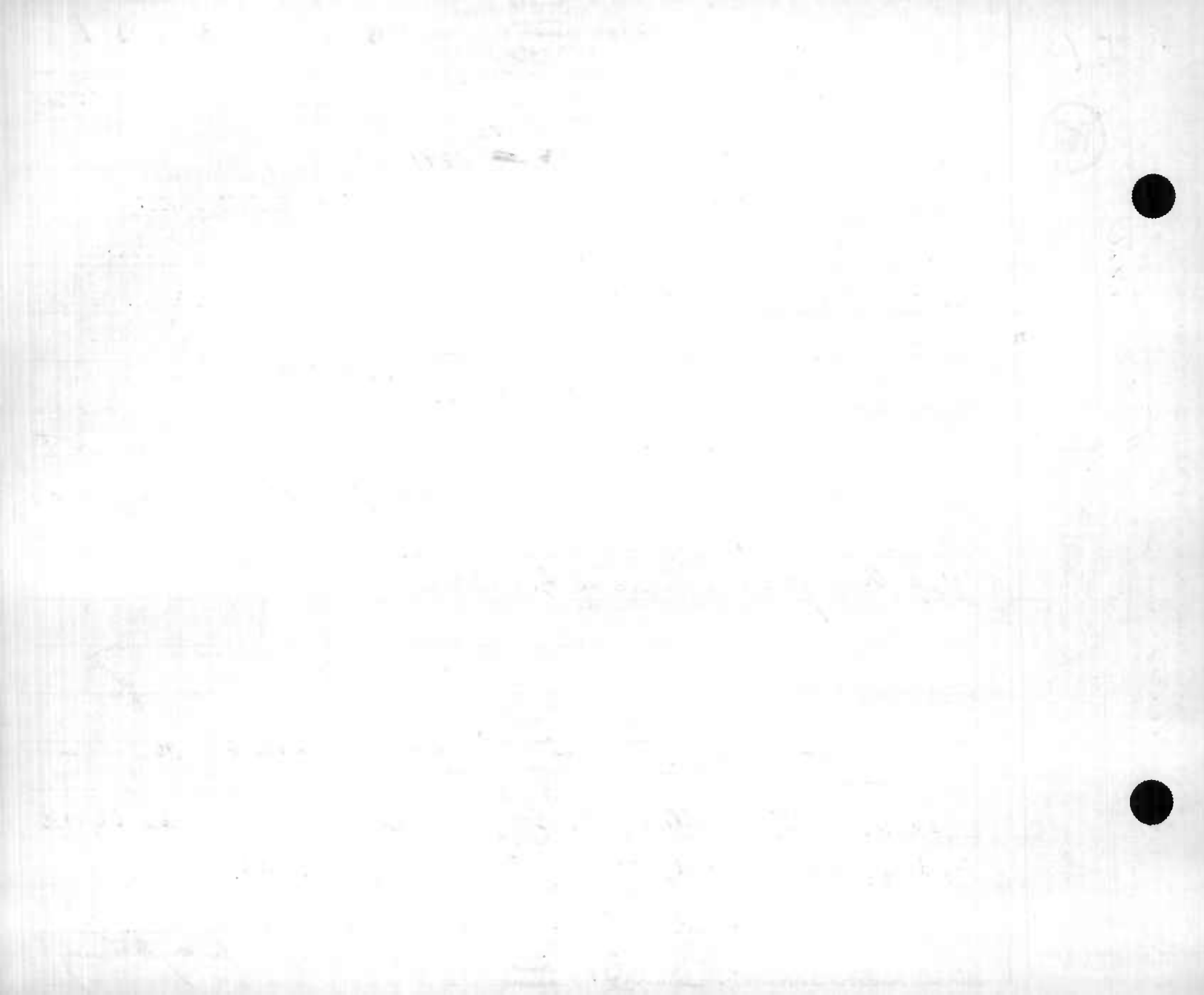
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				REG. NO.					
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE OF DEATH MONTH DAY YEAR		2c. HOUR	
Goldie		Vernica		Sampson				March 4 '80		2:25 AM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
Female		white		8 MONTH 23 1887		92		Virginia		USA	
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7d. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
Montgomery		MD		Rockville		Collingswood Nursing Home		Housewife		Home	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
Housewife		Home		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1700 Paragut Avenue		Virgil V. Weaver		Sally Claygett	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4340		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
no		577 18 5135		Roy Manuel same as 13c				Cerebrovascular Thrombosis		9 weeks	
								DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis		year	
								DUE TO, OR AS A CONSEQUENCE OF (c)			
								PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				HOUR A.M. MONTH DAY YEAR	
										P.M. 19	
21c. INJURY OCCURRED		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21e. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21f. LOCATION		21g. CITY OR TOWN		21h. COUNTY	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET		CITY OR TOWN		COUNTY	
										STATE	
22a. I certify that (I) (this hospital) attended the deceased from		19 75		to March 4 19 80		that (I) (we) lost		22b. SIGNATURE		DEGREE	
saw the deceased alive on Feb 24 19 80						and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		Attending Physician <input checked="" type="checkbox"/> Medical Director <input type="checkbox"/> Staff Physician <input type="checkbox"/>		22c. DATE SIGNED	
								Stuart G. Scott		3/5/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Stuart G. Scott		10401 Old Georgetown Rd. Bethesda, Md.		Burial				Ft. Lincoln Cemetery		Brentwood	
										COUNTY Maryland	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE REC'D. BY REGISTRAR		25d. REGISTRAR'S SIGNATURE		25e. DATE REC'D. BY REGISTRAR	
Wynson Wheeler Funeral Home, Inc.		MAR 10 1980		[Signature]						MAR 10 1980	
1331 Rockville Pike Rockville, Md. 20852											

TO HOSPITAL ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) LENA SANDLER			2a. DATE OF DEATH MONTH DAY YEAR MARCH 6, 1980				2b. HOUR 3:12AM		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 5, 1931 1891		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OWNER		12b. KIND OF BUSINESS OR INDUSTRY GROCERY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10412 BURNT EMBER DR. #20903	
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS LEVIN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETHEL PONTENOVITZ					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-48-6413A		17. INFORMANT MRS. ANNE ROSENBERG 10412 BURNT EMBER DR., SILVER SPRING, MD 20903			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Advanced atherosclerotic coronary heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4140</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>20 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Papillary Carcinoma of Bladder</u>									
18a. DATE OF OPERATION			18b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 1960</u> to <u>Mar 6, 1980</u> , that (I) (we) last saw the deceased alive on <u>Feb 26, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22a. SIGNATURE <u>Sydney Leventhal, M.D.</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>March 6, 1980</u>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Sydney Leventhal, M.D.</u>						22d. ADDRESS <u>Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE MAR. 7, 1980		23c. NAME OF CEMETERY OR CREMATORY HAR ZION TIFEREH ISRAELI		23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO. MD		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215						25. DATE RECEIVED BY REGISTRAR MAR 11 1980			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 008008			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ethel Ruth SAPP				2b. MAR 27, 80 7:15 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 17, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Asbury Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN 21204	
14. FATHER'S NAME FIRST MIDDLE LAST Fredrick W. Kroeber				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma L. Kaylor			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-01-0646		17. INFORMANT ADDRESS Louis F. Forster 3700 N. Charles St. 21218			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 436- CEREBRO-VASCULAR ACCIDENT (b) ARTERIO-SCLEROSIS (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from OCT 19 75 to 3/27 80, that (I) (we) lost saw the deceased alive on 3/26/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				22b. SIGNATURE THOS G- WARD 6116 ROBINWOOD, Bethesda, Md			
22c. PHYSICIAN'S NAME (TYPE OR PRINT) THOS G- WARD 6116 ROBINWOOD, Bethesda, Md				22d. ADDRESS 6116 ROBINWOOD, Bethesda, Md		22e. DATE SIGNED 3/28/80	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 31, '80		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS William E. Johnson 8521 Loch Raven Blvd. 21204				25a. DATE REC'D. BY REGISTRAR MAR 31 1980		25b. REGISTRAR'S SIGNATURE Dorothy McCreedy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 008009									
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
Merrill		A.		SAPPINGTON				March 12 1980		11:20A _{AM}	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR MONTHS DAYS		7 IF UNDER 24 HRS. HOURS MIN.	
Male		Caucasian		Jan. 28 1944		36		YRS.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Montgomery MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Bethesda		National Naval Medical Center						U. S. Navy			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS			
Virginia		Fairfax		Vienna				8500 Marquette Street			
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Merrill Homer Sappington		Kathryn Louise Brill									
16a WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT		ADDRESS					
Yes		1965-79		260 68 0230		Donna Sappington See item 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the lung complicated by ulceration</u> 1629 DUE TO, OR AS A CONSEQUENCE OF of right pulmonary artery with acute hemorrhage (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that I (this hospital) attended the deceased from <u>March 10</u> , 19 <u>80</u> , to <u>March 12</u> , 19 <u>80</u> , that I (we) lost saw the deceased alive on <u>March 12</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, I (we) (did) (did not) view the body after death.											
22b SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c DATE SIGNED	
Mark D. Browning M.D.										March 13 1980	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS									
Mark D. Browning, M.D.		National Naval Medical Center, Bethesda, Md.									
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE					
Burial		3-17-80		Arlington National		Arlington Arlington Va.					
24 FUNERAL DIRECTOR NAME		ADDRESS				25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
						MAR 18 1980		Morty McCurdy			

Wm. J. Lawrence

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 008010				
1. FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT) MARGUERITE D. SARTAIN			2a. DATE OF DEATH MONTH MARCH DAY 2 YEAR 80			2b. HOUR 12 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH NOV DAY 18 YEAR 1890		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		7. UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13e. STREET ADDRESS 511 DARTMOUTH AVENUE					14. FATHER'S NAME FIRST JAMES MIDDLE F. LAST CORRIDON				
15. MOTHER'S MAIDEN NAME FIRST WINIFRED MIDDLE KEELEY LAST KEELEY					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO 16b. SOCIAL SECURITY NO 578-40-8932				
17. INFORMANT SON ADDRESS 10702 BUCKNELL DR. SILVER SPRING, MD. 20902					18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) GRAM NEGATIVE CARDIO-PULMONARY ARREST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH M.I.N.S.				
DUE TO, OR AS A CONSEQUENCE OF (b) GRAM NEGATIVE SEPSIS 3 DAYS					DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) MITRAL INSUFFICIENCY; GENERALISED ARTERIOSCLEROSIS.					19a. DATE OF OPERATION				
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (X) (this hospital) attended the deceased from 2/26 19 80 to March 2 19 80 , that (1) (we) lost saw the deceased alive on March 1 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.									
22b. SIGNATURE Harold W. Draper M.D. DEGREE M.D.				22c. DATE SIGNED 3/3/80			22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD W. DRAPER M.D.		
22e. ADDRESS 9801 GEORGIA AVE, Silver Spring				23a. BURIAL, CREMATION, REMOVAL BURIAL 23b. DATE 3/5/80					
23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY				23d. LOCATION WASHINGTON, D.C. COUNTY MD STATE					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR MAR 4 1980			25b. REGISTRAR'S SIGNATURE Anthony Kelly		
26. ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901									

NO	275-40-1992	WILLIAM J. CAPTAIN	SON	10700 RUCKELT DR SILVER SPRING MD 20902
JAMES	F.	COOPERSON	WINTHED	KEELIN
WARLARD	MONTGOMERY	SILVER SPRING	X	511 DARTMOUTH AVENUE
SILVER SPRING	HOLY CROSS HOSPITAL	HOMEMAKER		
WASHINGTON, D. C.	U.S.A.	XX		
TERMIN	WHITE	NOV 12, 1890		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR STATE REGISTRAR			REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR
JULIUS SAUBER						MARCH 10, 1980			9:15 P
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN	
MALE	CAUCASIAN	March 14, 1902		77 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland	U.S.A.				Montgomery MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda	Bethesda Retirement Home				Florist		Wholesale		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS
Maryland			Montgomery		Chevy Ch.		YES		4620 North Park Ave.
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
Adolph Falk Sauber			Annie Graff						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
No			578-07-5865		Frank Sauber		Rockville, Md. 6908 Breezewood Terr.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>THROMBOSIS</u> <u>4340</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>cerebral thromboses</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>cerebral arteriosclerosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>month</u> <u>yes.</u> <u>yes.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>August 65</u> to <u>March 10 80</u> , that (I) <u>see</u> lost saw the deceased alive on <u>MARCH 10 19 80</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>was</u> (did) (did not) view the body after death.									
22b. SIGNATURE <u>Arnold A. Lear M.D.</u> DEGREE						22c. DATE SIGNED <u>3-11-80</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			
Arnold A. Lear M.D.						2201 L St. N.W. Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			3-12-1980		Adas Israel		Washington D.C.		
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
DANZANSKY-GOLDBERG MEMORIAL CHAPELS					MAR 17 1980		<u>Henry McCreedy</u>		

11/11/11

THE NEW YORK PUBLIC LIBRARY

11/11/11

[Faint, illegible handwriting on lined paper]

11-11-11

THE NEW YORK PUBLIC LIBRARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

5 0 0 8 0 1 2

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CORI LYNN SAUNDERS			2a. DATE OF DEATH MONTH DAY YEAR March 9, 1980			2b. HOUR 1:00 A M			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR September 5, 1972			6 AGE (IN YEARS LAST BIRTHDAY) 7 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH Clinical Center, Bethesda, Md			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Virginia			13b. CITY OR TOWN Salem		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 126 Otter Ave. #132 24153		
14 FATHER'S NAME FIRST MIDDLE LAST Anthony Alan Saunders			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Deborah Simmons Saunders						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 000-00-0000		17 INFORMANT ADDRESS (same as above) Mrs. Deborah S. Saunders (mother)				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiogenic shock</u> 2050 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Pneumonitis</u> (c) <u>Acute myelogenous leukemia</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21i. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 16, 1980, to March 9, 1980, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on March 9, 1980, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Katherine Seibert</i>			DEGREE M.D., PH.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/9/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KATHERINE SEIBERT			22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md 20205						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE March 12, 1980		23c. NAME OF CEMETERY OR CREMATORY Mill Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Fincastle Botetourt Virginia		
24 FUNERAL DIRECTOR NAME E.A. Graybill #62 Rader Funeral Home			ADDRESS Virginia P.O. Box 175, Troutville,		25a. DATE REC'D. BY REGISTRAR MAR 17 1980		25b. REGISTERED SIGNATURE <i>Katherine Seibert</i>		

USA Virginia

Anthony Alan Deborah Simone

Under Number 1001
P.O. Box 175, Frontville,
Virginia
March 12, 1980 Mill Creek Cemetery Frontville
of Frontville

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

08013

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ronald Earl Scantleberry			2a. DATE OF DEATH MONTH DAY YEAR 3 9 80		2b. HOUR 6³⁰ P. M.		
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 1 20 01		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 2 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hampton Iowa		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Herman H. Wilson H. Care		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Scientist		12b. KIND OF BUSINESS OR INDUSTRY NIH	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MD		13b. COUNTY Montg.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 403 Russell Ave							
14. FATHER'S NAME FIRST MIDDLE LAST Charles H. Scantleberry				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Kemphorn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-38-8238		17. INFORMANT ADDRESS "Health Care Center" Records Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular archythmia DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Arteriosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 min 2 years ± 10 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION 9/9		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from May 26 1977 to March 9 1980 , that (1) (we) lost saw the deceased alive on March 3 1980 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE James R Moore Jr. MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-10-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James R Moore Jr. MD		22e. ADDRESS 207 Brookes Ave Gaithersburg Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/10/80		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.	
24. FUNERAL DIRECTOR Gartner-Sandison F.H.		316 E. Diamond Ave. Gaithersburg, Md.		25a. DATE REC'D. BY REGISTRAR MAR 17 1980		25b. REGISTRAR'S SIGNATURE W. J. McCreedy	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

100-104-1101
MONTANA
PO BOX 104
MONTANA



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4

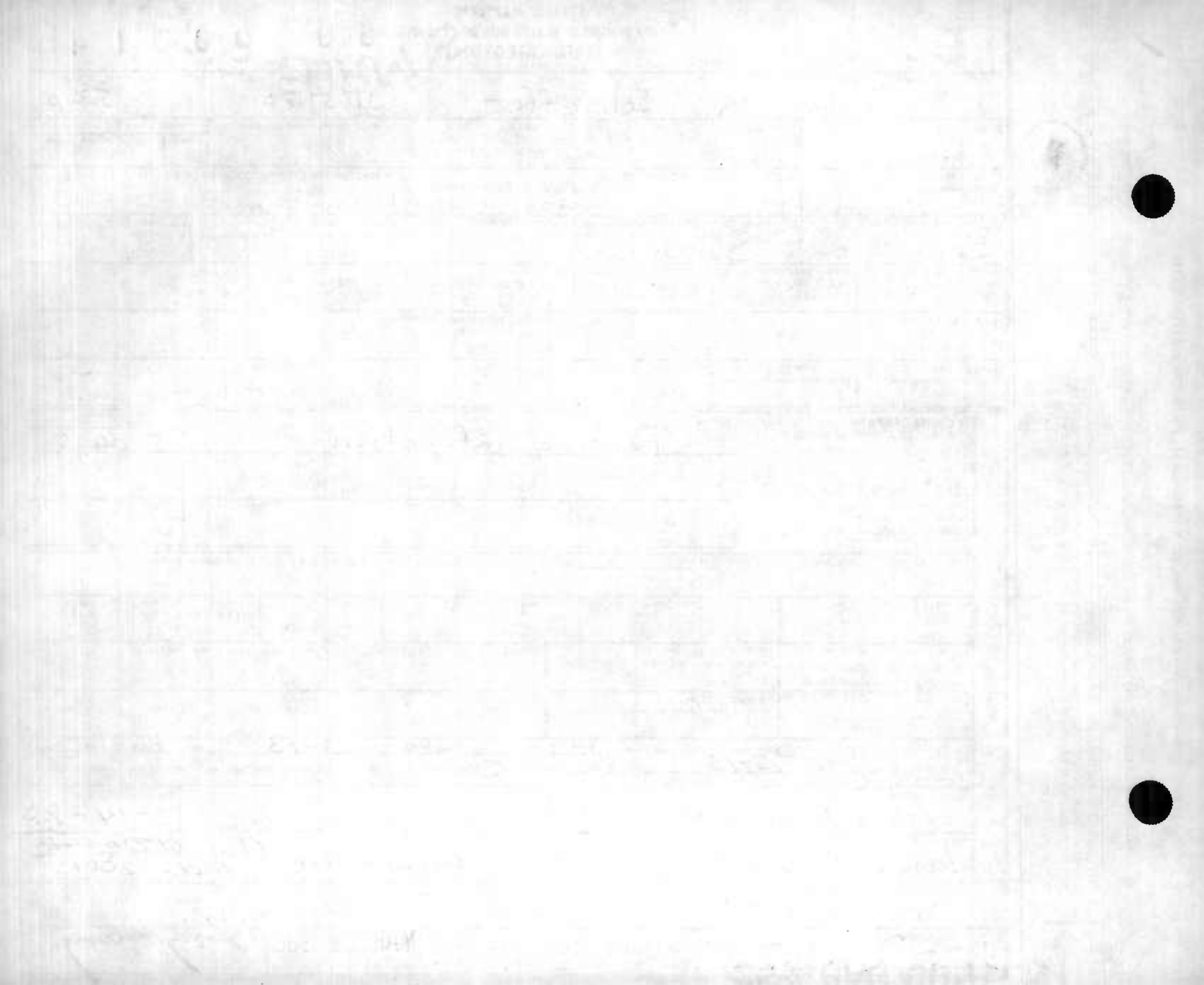
1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

0 0 8 0 1 4

1. DECEASED NAME (TYPE OR PRINT) Bewla R. Schaeffer			2a. DATE OF DEATH MONTH DAY YEAR 3/13/80			2b. HOUR 5:30 P.M.		
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR May 31 1889		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE Md		13b. COUNTY Mont/		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Albert Prettyman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Flora Redford				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 191-03-6189		17. INFORMANT ADDRESS Robert L. Schaeffer/10642 Montrose Ave. Bethesda, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pontine infarction DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3-9 19 80 , to 3-13 19 80 , that (I) (we) last saw the deceased alive on 3-13 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE James H. Brodsky		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-14-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James H. Brodsky		22e. ADDRESS 4701 Willard Ave Chevy Chase Md. 20015						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation		23b. DATE 3/14/80		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		
24. FUNERAL DIRECTOR NAME W. R. Lee		4510 Wilson Blvd. Arlington Va.		25a. DATE PROC'D BY REGISTRAR Mar 13 1980		25b. REGISTRAR'S SIGNATURE W. R. Lee		

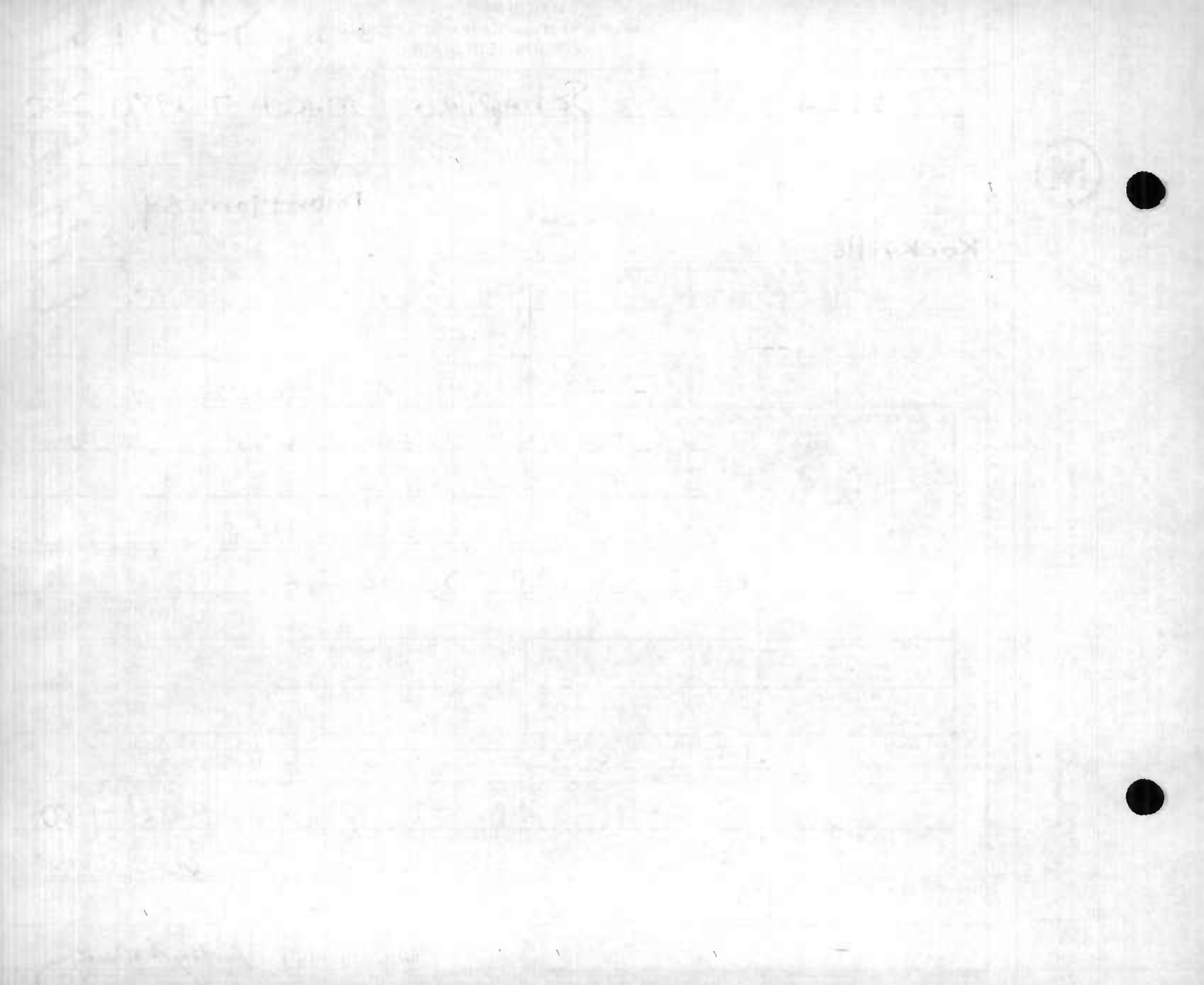


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 0008015							
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH MONTH DAY YEAR	
ELLA SAMUELSON						Schapiro		March 7 1980	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		2b HOUR	
FEMALE		CAUCASIAN		MARCH 19, 1887		92 YRS		2:05 P.M.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
POLAND		USA				Montgomery		MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Rockville		HEBREW HOME OF GREATER WASH.				HOMEMAKER			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?	
MARYLAND		MONTGOMERY		ROCKVILLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					
MEYER --- LYSKY		(UNKNOWN)		16b SOCIAL SECURITY NO. 321-09-2137A					
17 INFORMANT ADDRESS		HEBREW HOME, Rockville, Maryland							
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4370 DUE TO, OR AS A CONSEQUENCE OF (b) BULBAR PALSY DUE TO, OR AS A CONSEQUENCE OF (c) CEREBRAL ARTERIOSCLEROSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		24 HOURS					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: SEVERE SENILE DEMENTIA									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
—				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 4/1/1970 to 3/7/1980, that (I) (we) last saw the deceased alive on 3/7/1980 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did) (we) saw the body after death.									
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED			
D. D. PATEL		M.D.				3/7/80			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS							
D. D. PATEL		6121 MONTROSE RD. ROCKVILLE, MD.							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN		COUNTY STATE	
BURIAL		3/10/80		ANSHE KANESSES ISRAEL		FOREST PARK		ILLINOIS	
24 FUNERAL DIRECTOR				25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
DANZANSKY-GOLDBERG, ROCKVILLE, MD.				MAR 13 1980		[Signature]			

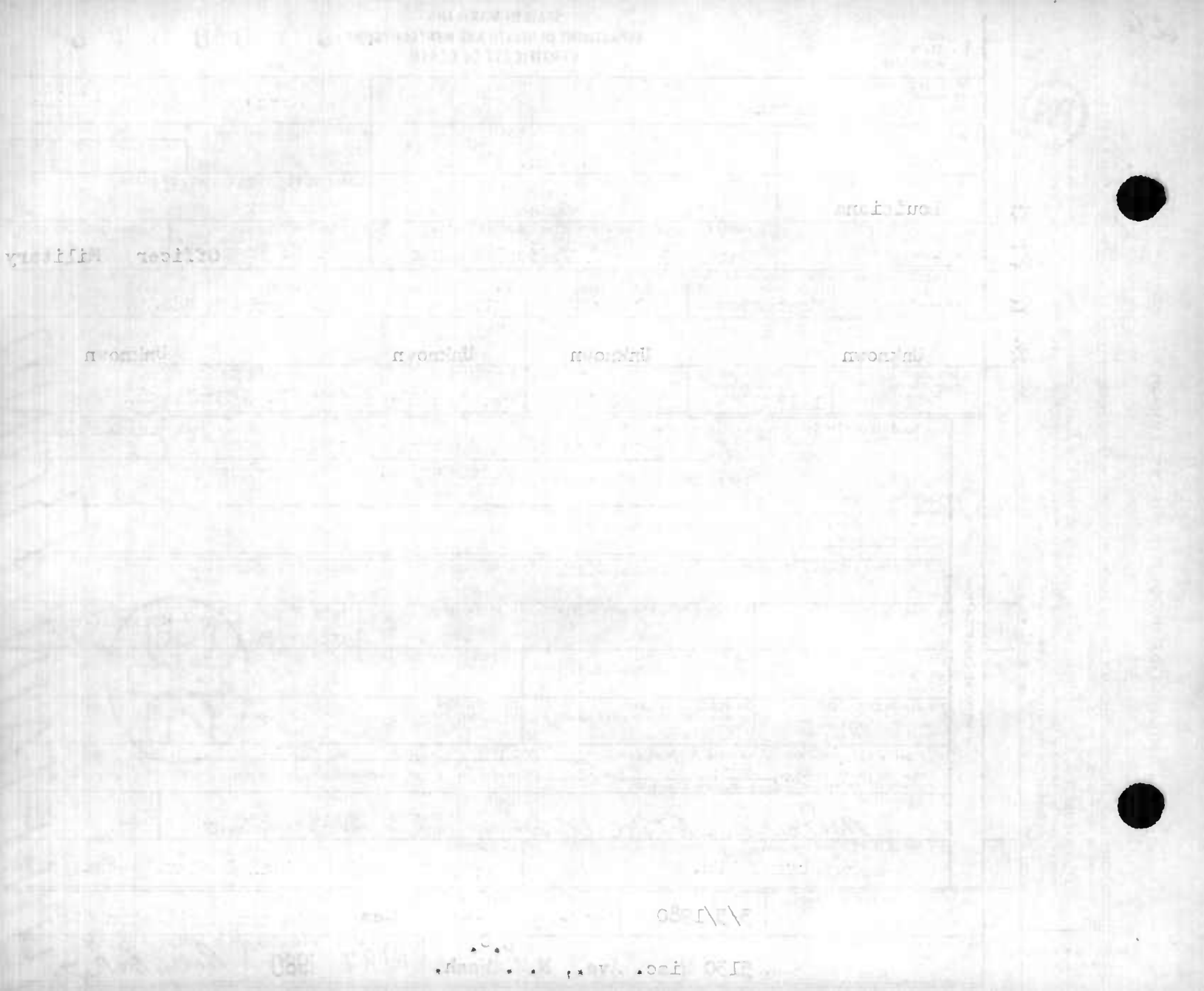


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																	
1. FOR STATE REGISTRAR		REG. NO.															
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
George		Scratchley						March		3		1980		1225A		M	
3. SEX		4. RACE		5. DATE OF BIRTH		MONTH		DAY		YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Caucasian		Jan. 23		1891		89		YRS				MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								MD	
Louisiana		USA						Montgomery									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Bethesda		National Naval Medical Center		U. S. Navy Officer		Military											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Maryland		Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5410 Lambeth Road									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Unknown		Unknown		Unknown		Unknown											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT													
Yes		1917-39		220 44 1382		Mrs. Lucille Smith, 7405 Honeywell Lane											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction complicated by</u> <u>410-</u> retroperitoneal hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from <u>March 2</u> , 19 <u>80</u> , to <u>March 3</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>March 3</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>M. Duran Lt MC USAF</u>		DEGREE		22c. DATE SIGNED													
				Mar. 4, 1980													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
M. Duran, M.D.		National Naval Medical Center, Bethesda, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		3/5/1980		Arlington National Cem		Arlington Arlington Va.											
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE RECD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Jos. Gawler Sons		5130 Wisc. Ave., N.W. Wash. D.C.		MAR 7 1980		<u>Patrick M. Brady</u>											





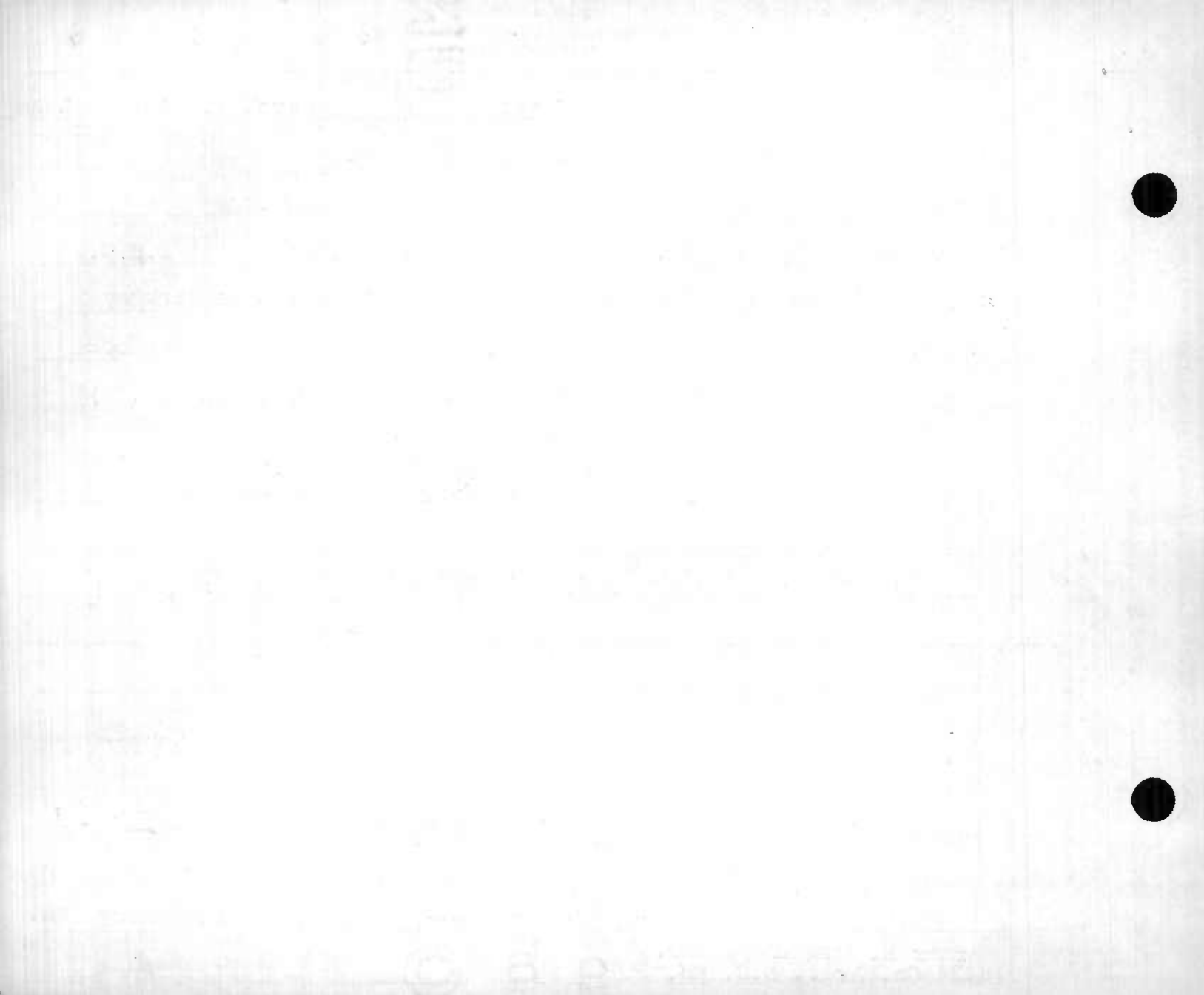
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										03/14/80 8 0 1 45 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) L. CECELIA SEABORN			2a. DATE OF DEATH MONTH DAY YEAR MARCH 14 1980			2b. HOUR 2:45 P.M.					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUG 17, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11701 JUDSON ROAD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SWITCHBOARD OPERATOR		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN WHEATON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11701 JUDSON ROAD			
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH AUGUSTUS SEABORN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUNA CORDELLA HOOK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-07-4749		17. INFORMANT NIECE GRACE DESCH		ADDRESS SAME AS 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphoma, probable, with metastases</u> 3028 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cerebral arteriosclerosis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>2/6</u> 19 <u>80</u> , to <u>3/14</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>3/10</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 3/14/80	
22b. SIGNATURE <u>George S. Kenton</u> M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE S. KENTON				22e. ADDRESS 10620 GEORGIA AVE SILVER SPRING MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/17/80		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR MAR 17 1980		25b. REGISTRAR'S SIGNATURE <u>Rafaela K. Brady</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR			REG. NO.										
1 DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH			MONTH		DAY		YEAR		2b HOUR	
Flora A. Seale			March		24		1980		2:23AM				
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		Apr. 9, 1907		72		MONTHS		DAYS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
Alabama		USA				Montgomery				MD			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY							
Takoma Park		Washington Adventist Hospital		Retired		H.E.W.							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a INSIDE CITY LIMITS?			13b STREET ADDRESS							
13a STATE 13b COUNTY 13c CITY OR TOWN			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			607 Woodside Parkway							
Maryland Montgomery Sil. Spring													
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME										
FIRST MIDDLE LAST			FIRST MIDDLE LAST										
Agustus Gamble			Clayde Barfoot										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b SOCIAL SECURITY NO			17 INFORMANT (husband) ADDRESS							
no			none			421-10-4571			Leady W. Seale, Sr.-(same as 13e)				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>myocardial infarction</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>diabetic mellitus, osteoarthritis, heart disease</u>													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
			P.M. 19										
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN COUNTY STATE				
22a I certify that (I) this hospital attended the deceased from <u>5/20</u> 19 <u>80</u> to <u>3/24</u> 19 <u>80</u> , that (I) (we) lost showed (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE										22c DATE SIGNED			
<u>Lewis H. Dennis, MD</u>										<u>3/25/80</u>			
22d PHYSICIAN'S NAME (TYPE OR PRINT)										22e ADDRESS			
Lewis H. Dennis, MD										831 Univ., Blvd., Silver Spring, Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION CITY OR TOWN COUNTY STATE					
Burial			3-27-80		Parklawn Cemetery			Rockville Montgomery Md.					
24 FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.						25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
						MAR 31 1980		<u>Robert M. Brady</u>					



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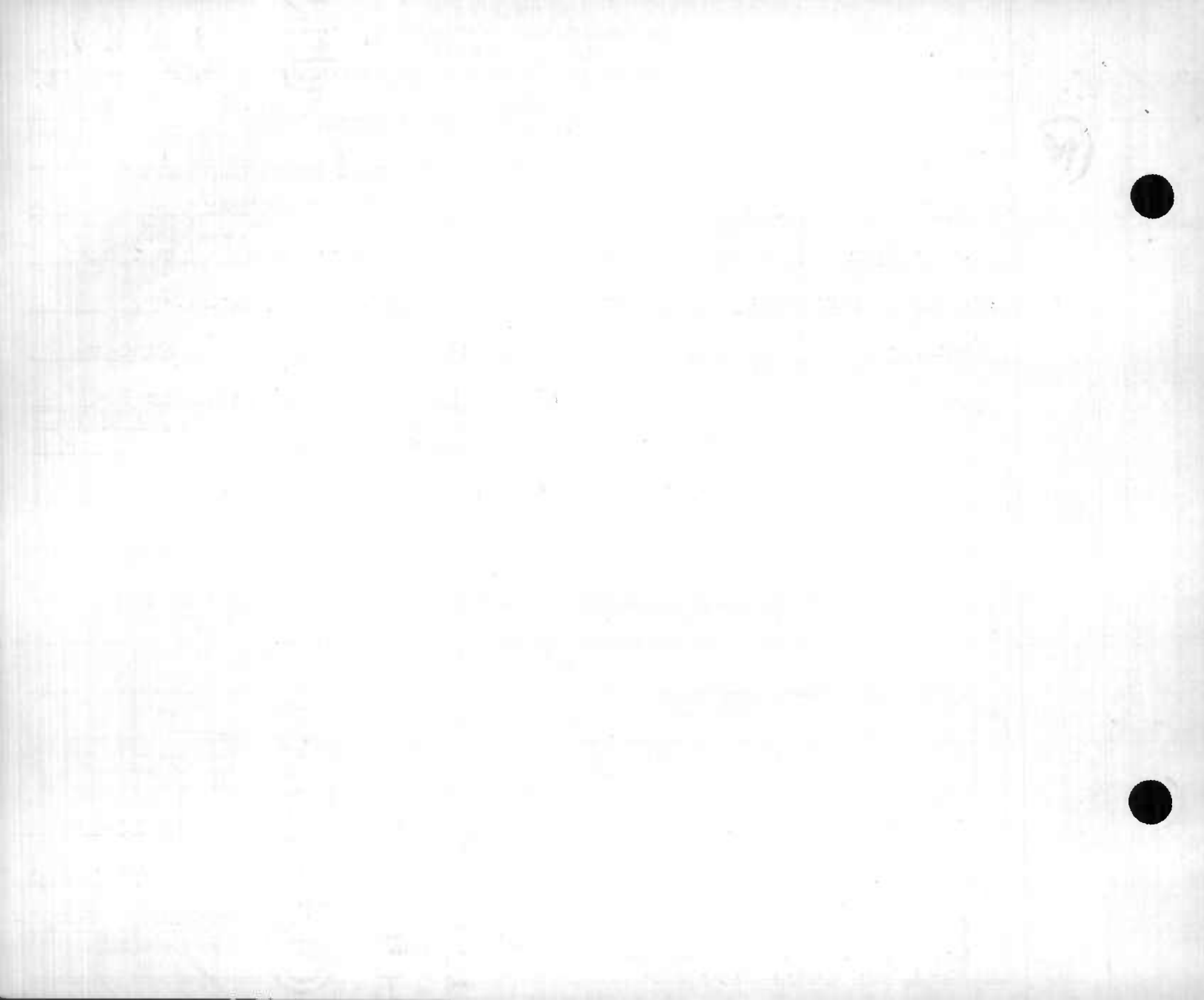
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

0 0 8 0 1 9

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Maude M. Seaton			2a. DATE OF DEATH MONTH DAY YEAR March 14 1980		2b. HOUR A. 8:15 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 21 1895	6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairland Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY own home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Sil. Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 911 Copley Lane,
14. FATHER'S NAME FIRST MIDDLE LAST Charles McGee		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Della Hunter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. D 191-09-5971	17. INFORMANT (son) ADDRESS Donald W. Seaton- (same as 13e)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) arterio sclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Feb 1980 to present 19 80 , that (I) (we) lost saw the deceased alive on March 5 19 80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. Merendino, MD		DEGREE MD		22c. DATE SIGNED 3-14-1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. MERENDINO, MD		22e. ADDRESS 11620 Kemp Mill Rd 20902			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3-17-1980	23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Dunbar Fayette Penna.		
24. FUNERAL DIRECTOR Warner E. Pumphrey, Jr. 8434 Ga. Ave., S/S. Md.		25. RECEIVED BY REGISTRAR MAR 15 1980		25b. REGISTRAR'S SIGNATURE John E. McLean	



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 008020							
1. FOR STATE REGISTRAR																	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Richard Douglas Seel						2a. DATE OF DEATH MONTH DAY YEAR MARCH 13, 1980				2b. HOUR 12³⁰ A M							
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11-21-1909		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) So. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont. MD.											
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adv. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Brick Mason			12b. KIND OF BUSINESS OR INDUSTRY								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.										13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Mt. Rainier		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4226 - 34th Street	
14. FATHER'S NAME FIRST MIDDLE LAST Harry M. Seel						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jessie I. Daniels											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 250-03-85824		17. INFORMANT ADDRESS Same as				17. INFORMANT Alsa U. Seel (Wife) above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Met. Lung Cancer (c) 6 months										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from JUN 80 to 13 MAR 80 , that (I) (we) last saw the deceased alive on 12 MAR 80 19 80 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Thomas A. Bensinger MD						DEGREE MD			22c. DATE SIGNED 13 MAR 80								
22b. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS A. BENNINGER, MD						22c. ADDRESS 831 University Blvd E. St. Spg Md											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3-15-80		23c. NAME OF CEMETERY OR CREMATORY Md. Nat. Cem.			23d. LOCATION CITY OR TOWN COUNTY Laurel Pr. Geo. Md.								
24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc.						ADDRESS Mt. Rainier, Md.			25a. DATE REC'D. BY REGISTRAR MAR 18 1980		25b. REGISTRAR'S SIGNATURE <i>Kirby McHenry</i>						





No

[Faint, mostly illegible text and markings covering the majority of the page, possibly bleed-through from the reverse side.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					REG. NO. 008021				
1. DECEASED NAME (TYPE OR PRINT) ISABEL H. SELBST					2a. DATE OF DEATH MONTH 3 DAY 14 YEAR 80			2b. HOUR 2:38 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH June DAY 2 YEAR 1900		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Nahum MIDDLE ----- LAST Heartstone		15. MOTHER'S MAIDEN NAME FIRST Rose MIDDLE ----- LAST Rubin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 156-01-3606B		17. INFORMANT ADDRESS Silver Spring, Md. Norman Selbst; 10509 Sweetbriar Parkway					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4292 DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic cardiovascular disease									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1978 19 present , that (I) (we) last saw the deceased alive on March 13 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Merendino				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3-14-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. MERENDINO				22e. ADDRESS 11620 Kemp Mill Rd. SSuz902					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-16-80		23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Gardens		23d. LOCATION CITY OR TOWN Norbeck, Maryland COUNTY STATE			
24. FUNERAL DIRECTOR NAME DANZANSKY GOLDBERG ADDRESS 1170 ROCKVILLE AVE				25a. DATE REC'D. BY REGISTRAR MAR 19 1980		25b. REGISTRAR'S SIGNATURE notary/legislator			

BP

15-06-2014

28-06-2014

Handwritten notes in the top section of the page, including the date 28-06-2014.

Handwritten notes in the middle section of the page.

Handwritten notes in the bottom section of the page, including the date 28-06-2014.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

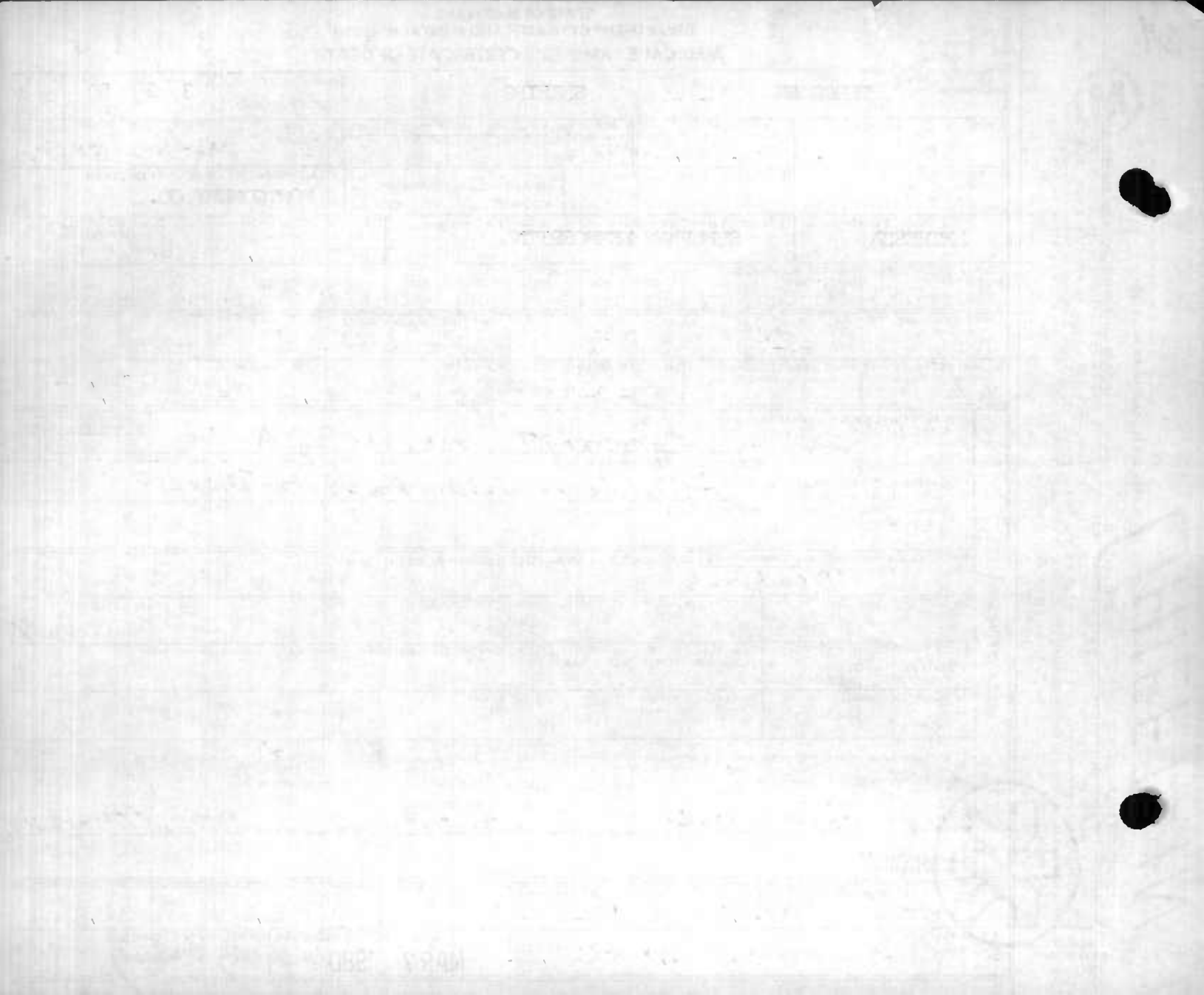
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 0 0 8 0 2 2							
1. DECEASED NAME (TYPE OR PRINT) BEN					2a. DATE OF DEATH MONTH 3 DAY 4 YEAR 80			2b. HOUR 3 ¹⁵ ^A M	
3. SEX M		4. RACE Caucasian		5. DATE OF BIRTH MONTH Oct. DAY 5 YEAR 1905		6. AGE (IN YEARS LAST BIRTHDAY) 74 YEARS		7. IF UNDER 24 HRS. MONTHS 0 DAYS 0 HOURS 0 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Pharmaceutical	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1052 Ruatan Street			
14. FATHER'S NAME FIRST Jacob MIDDLE ---- LAST Shapiro		15. MOTHER'S MAIDEN NAME FIRST Gisla MIDDLE ---- LAST Greenspoon							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Maryland Ben Glassman, 1052 Ruatan St., Silver Spring,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic Shock 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Arteriosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs 10/8/73 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Chronic Lymphocytic Leukemia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/8 19 73 , to 3/4 19 80 , that (I) (we) lost saw the deceased alive on 3/3 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE T. James Waters, M.D.		DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/4/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. JAMES WATERS, M.D.		22e. ADDRESS 5530 WISCONSIN AVE CHEVY CHASE, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-6-80		23c. NAME OF CEMETERY OR CREMATORY Farband Labor Zionist		23d. LOCATION CITY OR TOWN Montreal, Canada COUNTY STATE			
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEM. CHAP. Rockville, Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR MAR 10 1980		25b. REGISTRAR'S SIGNATURE Hickey/McCreedy			

24

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH08023
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THEODORE SHAPIRO			2a. DATE KNOWN OF DEATH MONTH 3 DAY 2 YEAR 80			2b. HOUR 3:31 PM		
3. SEX Male	4. RACE Cauc.	5. DATE OF BIRTH MONTH Dec. DAY 29 YEAR 14	6. AGE (IN YEARS) LAST BIRTHDAY 65 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN. 	2c. DATE PRONOUNCED DEAD March 2 1980		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO.		
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT SUBURBAN HOSPITAL) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) President, American Meat Co.		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 8501 Thornden Terrace		
14. FATHER'S NAME FIRST Joseph MIDDLE - - - LAST Shapiro			15. MOTHER'S MAIDEN NAME FIRST Lena MIDDLE - - - LAST Aaronson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 578-03-7120		17. INFORMANT ADDRESS Chevy Chase, Md. Lawrence Shapiro, 6414 Western Ave,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency Acute. 411- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Hypertensive Cardio Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Diabetes								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE John H. Ball			TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER			DATE SIGNED March 2, 1980		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar. 4, 1980		23c. NAME OF CEMETERY OR CREMATORY B'Nai Israel		23d. LOCATION CITY OR TOWN Oxen Hill, Prince George, Md. COUNTY STATE	
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Mem. Chap., Rockville, Md. ADDRESS					25a. DATE REC'D. BY REGISTRAR MAR 7 1980		25b. REGISTRAR'S SIGNATURE Deputy Registrar	



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 0 0 8 0 2 4			
1. DECEASED NAME (TYPE OR PRINT) EMILY M. SHEA						2a. DATE OF DEATH MONTH DAY YEAR MAR 30 1980				2b. HOUR 5:30 AM			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 23 02		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.							
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBAROBAN				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS					
13a STATE MARYLAND		13b COUNTY MONTGOMERY		13c CITY OR TOWN CHEVY CHASE		13e STREET ADDRESS 4750 CHEVY CHASE DRIVE							
14 FATHER'S NAME FIRST MIDDLE LAST GUSTAV HORNIG						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY L. HARTEL							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 577-58-2966		17 INFORMANT SON JOHN J. SHEA		17b ADDRESS 11571 MONONGAHELA DRIVE ROCKVILLE, MD.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST 5609 DUE TO, OR AS A CONSEQUENCE OF (b) SHOCK & GASTROINTESTINAL BLEEDING Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) INTESTINAL OBSTRUCTION										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MINUTES 6 HOURS 7 WEEKS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (i) ASPIRATION PNEUMONIA; ARTERIOSCLEROSIS													
19a DATE OF OPERATION FEB. 1980		19b CONDITION FOR WHICH OPERATION WAS PERFORMED INTESTINAL OBSTRUCTION				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from JAN. 30 , 19 80 , to MARCH 30 , 19 80 , that (I) was last saw the deceased alive on MARCH 29 , 19 80 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) will did not view the body after death.													
22b. SIGNATURE Joseph D. Connor M.D.						DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED MARCH 31, 1980					
22a. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH D. CONNOR						22e ADDRESS 9420 OLD GEORGETOWN RD. BETH., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/1/80		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON D.C.							
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR APR 3 1980		25b. REGISTRAR'S SIGNATURE F. J. Collins					
500 UNIV. BLVD. W. SILVER SPRING, MD. 20901													

UNITED STATES DEPARTMENT OF JUSTICE
WASHINGTON, D. C.

NOV 19 1964

WASHINGTON, D. C.

WASHINGTON

WASHINGTON, D. C. NOV 19 1964

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WASHINGTON, D. C. NOV 19 1964

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 0 8 0 2 5

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Harry Shewell			2a. DATE OF DEATH MONTH DAY YEAR 3-8-80		2b. HOUR 100 P.M.
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH DAY MONTH YEAR May 6-1922	6 AGE (IN YEARS LAST BIRTHDAY) 57 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massant Villio N.Y.	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10 CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Architect Supervisor		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND	13b. COUNTY FREDERICK	13c. CITY OR TOWN MYERSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS ROUTE 1, BOX 310	
14 FATHER'S NAME FIRST MIDDLE LAST Robert M. Shewell		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Savers		ADDRESS (SAME AS #13 ABOVE) (SAME AS #13 ABOVE)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO 1WW II 5TT-28-7544		17 INFORMANT MRS. MARTHA SHEWELL	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) multiple myeloma DUE TO, OR AS A CONSEQUENCE OF 2030 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I, this hospital, attended the deceased from 2/10 , 19 79 , to 3/8 , 19 80 , that (a) (we) lost 0 saw (he) (she) (it) (we) (did not) view the body after death.					
22b. SIGNATURE Lewis H. Dennis		DEGREE		22c. DATE SIGNED 3/8/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis H. Dennis		22e. ADDRESS 831 University Blvd. Silver Spring, Maryland.			
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial		23b. DATE Mar. 12-1980		23c. NAME OF CEMETERY OR CREMATORY Harmony Church of Bethesda	
24 FUNERAL DIRECTOR NAME Arthur Walters		ADDRESS 254 Carroll ST NW Washington D.C. 20012		25a. DATE REC'D. BY REGISTRAR MAR 17 1980	
25b. REGISTRAR'S SIGNATURE Robert McCreedy					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and page 4 must be completed.



ANY

WHITE

MALE

U.S.A

MONTGOMERY

WASHINGTON ADVENTIST

MARTHA FREDERICK PIERCEVILLE

ROUTE 1, BOX 310

(NAME AS IN ABOVE)

MRS MARTHA SWEET

YES

Handwritten signature

of 5/15 to 21/20

Handwritten signature

801 University Blvd. Silver Spring, Maryland

Level 1, Condo

224 Carroll St NW
Washington DC 20001

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 15 WORKING DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME(5))
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										08026 REG. NO.	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Charles Ricky Silver						2a. DATE KNOWN OF DEATH ESTIMATED March 3 1980		2b. HOUR 12 PM			
3. SEX M		4. RACE AMERICAN INDIAN		5. DATE OF BIRTH MONTH DAY YEAR July 16 54		6. AGE (IN YEARS) (LAST BIRTHDAY) 23 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD March 3 1980	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D. C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12402 Barbara Rd				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 12402 Barbara Rd	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES H. SILVER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLONNIE LOUISE EVANS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 218-68-3438		17. INFORMANT FLONNIE L. SILVER				ADDRESS SAME AS 13 MOTHER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9551 IMMEDIATE CAUSE (a) Gunshot Wound of Head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 12 PM 3 3 1980				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12 PM 3 3 1980				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Shot with a 12 shotgun			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Barbara Rd Silver Spring Montgomery MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers				TITLE (SPECIFY) M.D. Dep				MEDICAL EXAMINER		DATE SIGNED March 3 1980	
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS				ADDRESS 1919 SEMINARY RD., SILVER SPRING MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 3/7/80		23c. NAME OF CEMETERY OR CREMATORY MT. BETHEL INDIAN BAPTIST CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE WARRENTON N CAROLINA			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						25a. DATE REC'D. BY REGISTRAR MAR 10 1980		25b. REGISTRAR'S SIGNATURE L. H. McCreedy			

AMERICAN
INDIA

WASHINGTON, D. C. U.S.A.

STREET

CHARLES M. FLOWERS
STREET FLOWERS
FLORENCE FLOWERS
STREET FLORENCE

NO. 12-66-7411 FLORENCE A. STREET
STREET AS 17 FLORENCE

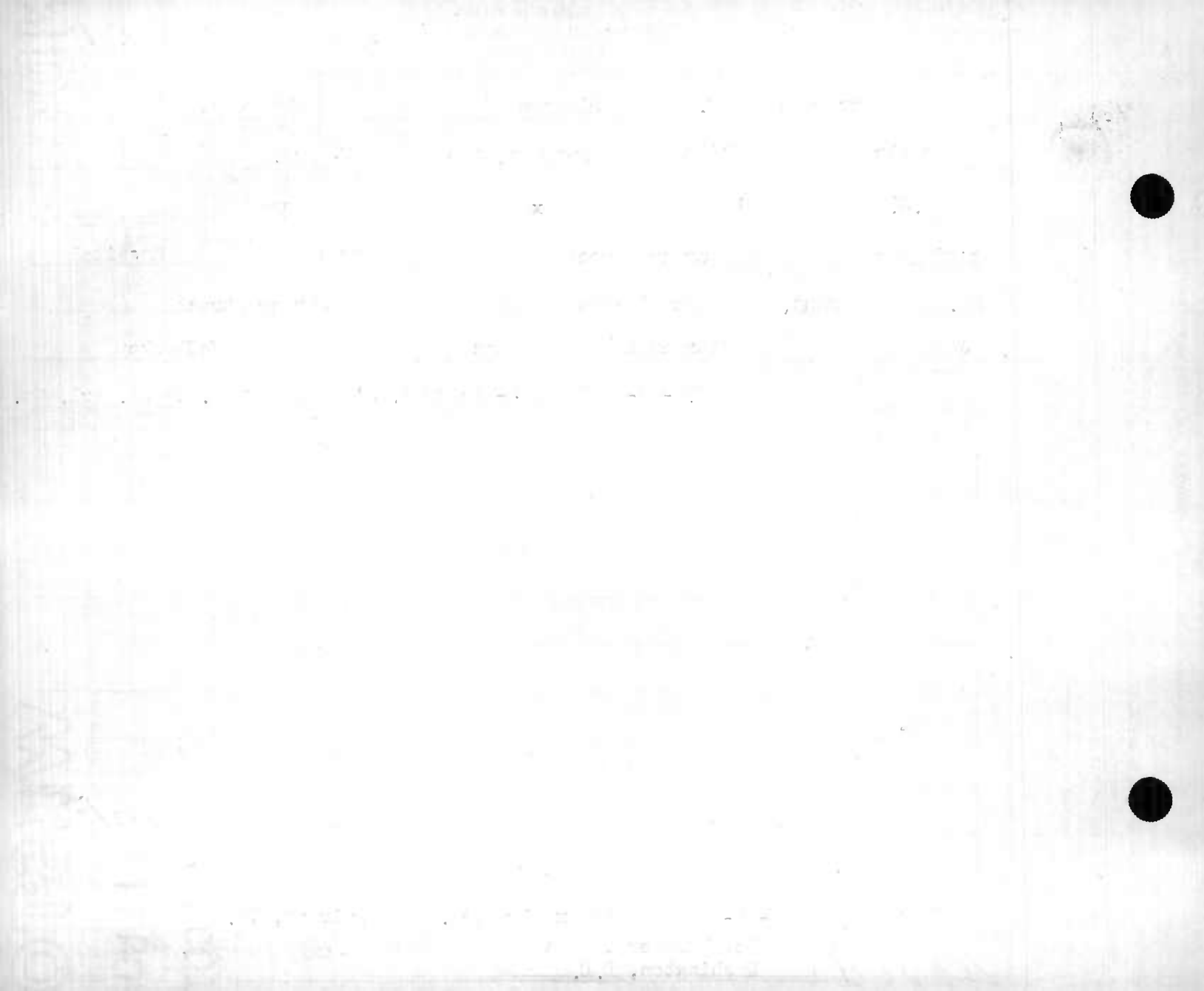
1912 SEPTEMBER 27
JAMES E. ROBERTS
BUREAU
WASHINGTON, D. C.
MAY 1 1913
JAMES E. ROBERTS
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0 0 8 0 2 7			
1. DECEASED NAME (TYPE OR PRINT) Gertrude F. Simpson				2a. DATE OF DEATH MONTH DAY YEAR MAR 13, 1980				2b. HOUR 8:00 A.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 23, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 74 yrs.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.J.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4213 Warner Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY Hospital			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Mont.		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4213 Warner Street	
14. FATHER'S NAME FIRST MIDDLE LAST John Fitzgerald				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann McCloskey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 578-44-3057		17. INFORMANT ADDRESS Son-Winter B. Simpson 5992 N. 9th St. Arl. Va.					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 4029 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive cardiovascular disease</u> 15 yrs DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Osteoporosis</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <u>2/9</u> , 19 <u>73</u> , to <u>3/13</u> , 19 <u>80</u> , that (1) (we) lost saw the deceased alive on <u>3/11</u> , 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death.											
22b. SIGNATURE <u>Georg Kenton, MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/13/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>GEORGES KENTON</u>				22e. ADDRESS <u>10620 GEORGIA AVE, SILVER SPRING, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3-17-80		23c. NAME OF CEMETERY OR CREMATORY Fairfax City Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Fairfax, Va. Md.			
24. FUNERAL DIRECTOR <u>DeVol Funeral Home</u>				25a. DATE RECD. BY REGISTRAR MAR 19 1980				25b. REGISTRAR'S SIGNATURE <u>M. J. McCloskey</u>			



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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0 0 8 0 2 8			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR			
Guy W. SINGLETON				March 21, 1980 2:20 am			
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS (LAST BIRTHDAY)) MONTHS DAYS HOURS MIN	
Male		CAUCASIAN		5 10 99		80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
KANSAS		U.S.A.				MONTGOMERY County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Bethesda Health Center		ENGINEER		Construction	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Maryland Montgomery Bethesda						10506 Weymouth St. APT. 101	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Samuel Singleton				Helen Woodworth			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS			
Yes		WW I		398-07-2477 Gladys M. Singleton, Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
438- Pneumonia							5 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							17 years
Multiple cerebrovascular accidents							indefinite
Atherosclerosis							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
none		none					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		none					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 3/18/80 to March 21, 1980, that (I) (we) lost the deceased alive on 3/18/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Allen S. O'Neill MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		3/21/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Allen S. O'Neill MD				8601 old Georgetown Rd. Bethesda Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation		3-22-80		Metropolitan Crem.		Alexandria, Virginia	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
ROBERT A. PUMPHREY FUNERAL HOMES, P. A., Bethesda, Maryland				3/22/80			



[Faint, mostly illegible text across the page, possibly a form or document with multiple lines of writing.]

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Denise Francoise Sked					2a DATE OF DEATH MONTH DAY YEAR March 3, 1980			2b HOUR P 2:58 AM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR May 22, 1920		6 AGE (IN YEARS LAST BIRTHDAY) YRS. 59		7 UNDER 1 YEAR MONTHS DAYS 7 UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) UNKNOWN		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, Bethesda, Md				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNKNOWN		12b KIND OF BUSINESS OR INDUSTRY UNKNOWN	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE COUNTY New Jersey					13c CITY OR TOWN Trenton		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST - UNKNOWN -					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST - UNKNOWN -				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO NONE		17 INFORMANT ADDRESS Mrs. Rita Gail Coyle, 6814 Lynford St. Philadelphia, Pa 19149					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) SEPSIS									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HOURS
1830 } DUE TO, OR AS A CONSEQUENCE OF (b) RADIATION INDUCED FISTULA									3 YEARS
DUE TO, OR AS A CONSEQUENCE OF (c) OVARIAN CARCINOMA									3 YEARS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 6, 1979, to March 3, 1980, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 3, 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.									
22b SIGNATURE <i>Max Wicha M.D.</i> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c DATE SIGNED					
22d PHYSICIAN'S NAME (TYPE OR PRINT) MAX WICHA MD				22e ADDRESS National Institutes of Health Clinical Center, Bethesda, Md 20205					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b DATE MARCH 5, 1980		23c NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE SUITLAND, P.D. CO. MARYLAND		23e DATE OF BURIAL MARCH 10 1980	
24 FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME - SILVER SPRING, MD.				25 ADDRESS MAY 10 1980					

BP

Item 15 8544 6/13/80 gj

FOR
1 - STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

0 8 0 3 0

1. DECEASED NAME (TYPE OR PRINT) CLARENCE H. SLAYTON			2a. DATE OF DEATH MONTH MAR DAY 30 YEAR 80			2b. HOUR 1:00 A.M.		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH JAN. DAY 8 YEAR 1888		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IOWA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ROCKVILLE NURSING HOME			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED MECH. ENGR.		12b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST CLARENCE MIDDLE EUGENE LAST SLAYTON		15. MOTHER'S MAIDEN NAME FIRST SARAH MIDDLE Clara LAST Melissa TODD						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS 10 MILLWOOD RD. MT. AIRY, MD. 21771				

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4140 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DIS DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS YEARS YEARS	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his/her) attended the deceased from MAR 79 to 3/30 80 , that (I) (we) lost saw the deceased alive on 3/26 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (not) view the body after death.							
22b. SIGNATURE Thos G. Ward				DEGREE MD.		22c. DATE SIGNED 3/30/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. Ward				22e. ADDRESS 6116 ROBINWOOD BETHESDA, MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 3-31-80		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA FAIRFAX VIRGINIA	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY FUNERAL HOMES P/A				ADDRESS ROCKVILLE MD.		DATE REC'D. BY REGISTRAR APR 7 1980	

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90
35
151
1
2
9
1
1005 BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 08031			
1. FOR STATE REGISTRAR				2. DATE OF DEATH MONTH DAY YEAR 3-10-80			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Bessie E. Smith</u>				3. HOUR 3:30 PM			
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>January 4-1892</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>88</u>	
7a. BIRTHPLACE (Country) <u>Logan Co. Penna.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>MD</u>	
10. CITY OR TOWN OF DEATH <u>Takoma Park</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH CHURCH) (ONE STREET ADDRESS) <u>Washington Monument Hospital N.H. Employees Retired</u>		12. USUAL OCCUPATION (TYPE BY WORK OR BASIS OF WORKING LIFE) <u>Retired</u>		13. STREET ADDRESS <u>1309 - Flower Ave. Takoma</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>William H. Smith</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Emma E. Smith</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>				16b. SOCIAL SECURITY NO. <u>220-34-4986A</u>			
17. INFORMANT ADDRESS <u>614 McKee St. Takoma Park</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4409 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Dementia</u>							
DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerosis</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1978</u> to <u>3-10-80</u> , that (I) (we) last saw the deceased alive on <u>3-9-80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>M. Snow MD</u> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3-10-80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. SNOW MD</u>				22e. ADDRESS <u>8013 FLOWER AVE SILVER SPRING MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Mar 13, 1980</u>		23c. NAME OF CEMETERY OR CREMATORY <u>See Washington Monument Hospital</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>2090</u>	
24. FUNERAL DIRECTOR <u>McKee Walters</u>				25. DATE REC'D. BY REGISTRAR <u>17 1980</u>			

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

08032

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHARLES REGINALD SMITH		2a. DATE OF DEATH MONTH DAY YEAR 3-29-80		2b. HOUR 7:45 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Nov. 21, 1919	
6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY Co. MD.	
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EXECUTIVE ASSIST PHYSICS.	
12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND.		13b. COUNTY Montgomery	
13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 13211 MAY COURT	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES G. SMITH		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAGGIE SMITH.		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 229-09-074		17. INFORMANT (wife) ADDRESS DORIS V. SMITH SAME AS 13e.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRAIN METASTASIS DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF PROSTATE DUE TO, OR AS A CONSEQUENCE OF (c) 2 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION 3/28		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from Jan. 19, 80 to 3/29 19 80 , that (I) (we) lost saw the deceased alive on 3/28 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Michael C. Brice	
22c. DATE SIGNED 3/29/80		22d. PHYSICIAN'S NAME (TYPE OR PRINT) KIRKLAND C. BRICE		22e. ADDRESS 7600 CARROLL AVE TAKOMA PARK, MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3-29-80		23c. NAME OF CEMETERY OR CREMATORY Metropolitan	
23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Fairfax Va.		24. FUNERAL DIRECTOR'S NAME Warner E. Pumphrey, Inc.		25a. DATE REC'D. BY REGISTRAR APR 3 1980	
25b. REGISTRAR'S SIGNATURE Robert E. McShane		25c. ADDRESS 8434 Ga. Ave., S.S. Md.		25d. ADDRESS	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

Handwritten notes on lined paper, including a large circular diagram in the center. The text is mostly illegible due to fading and bleed-through.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

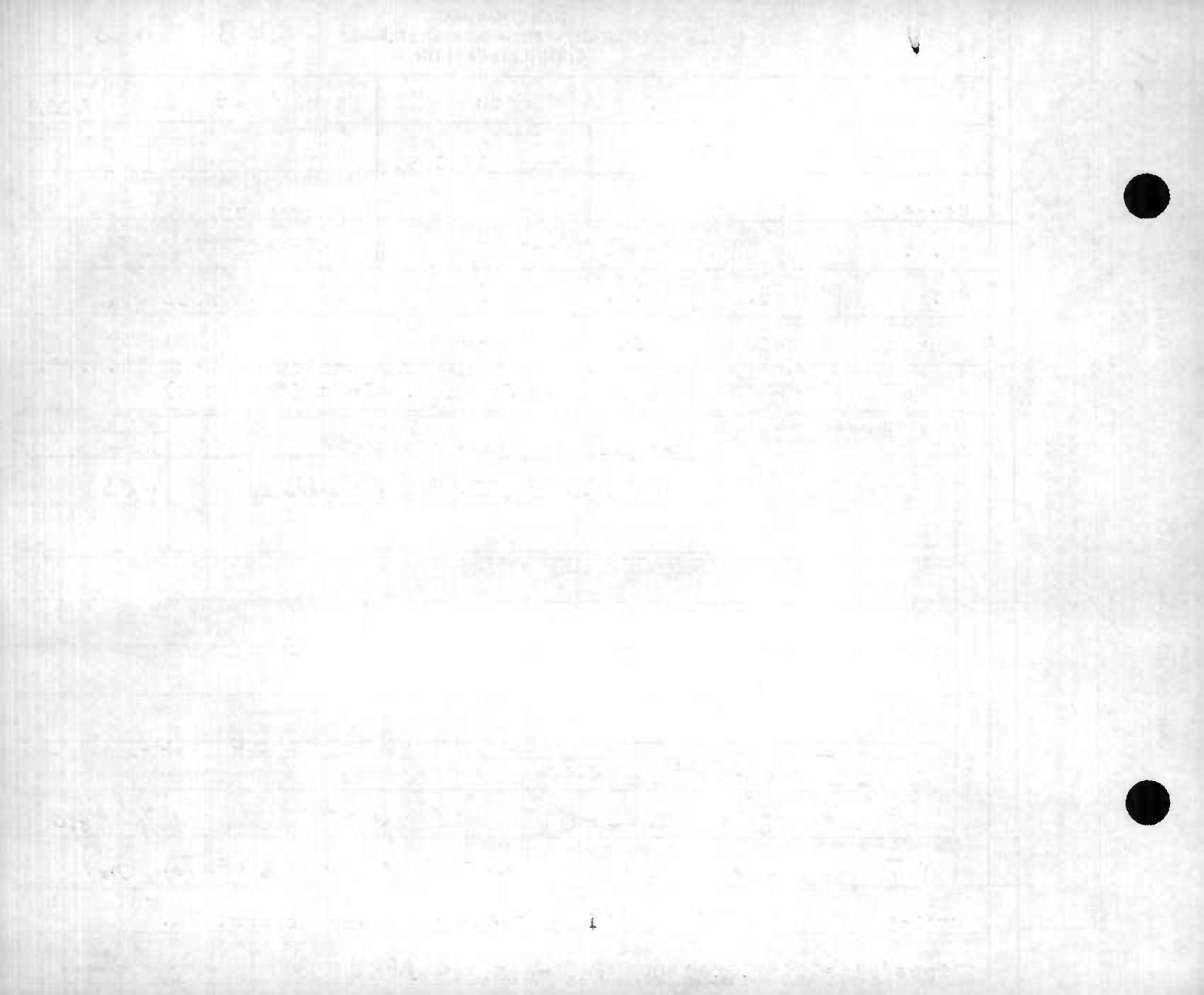
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

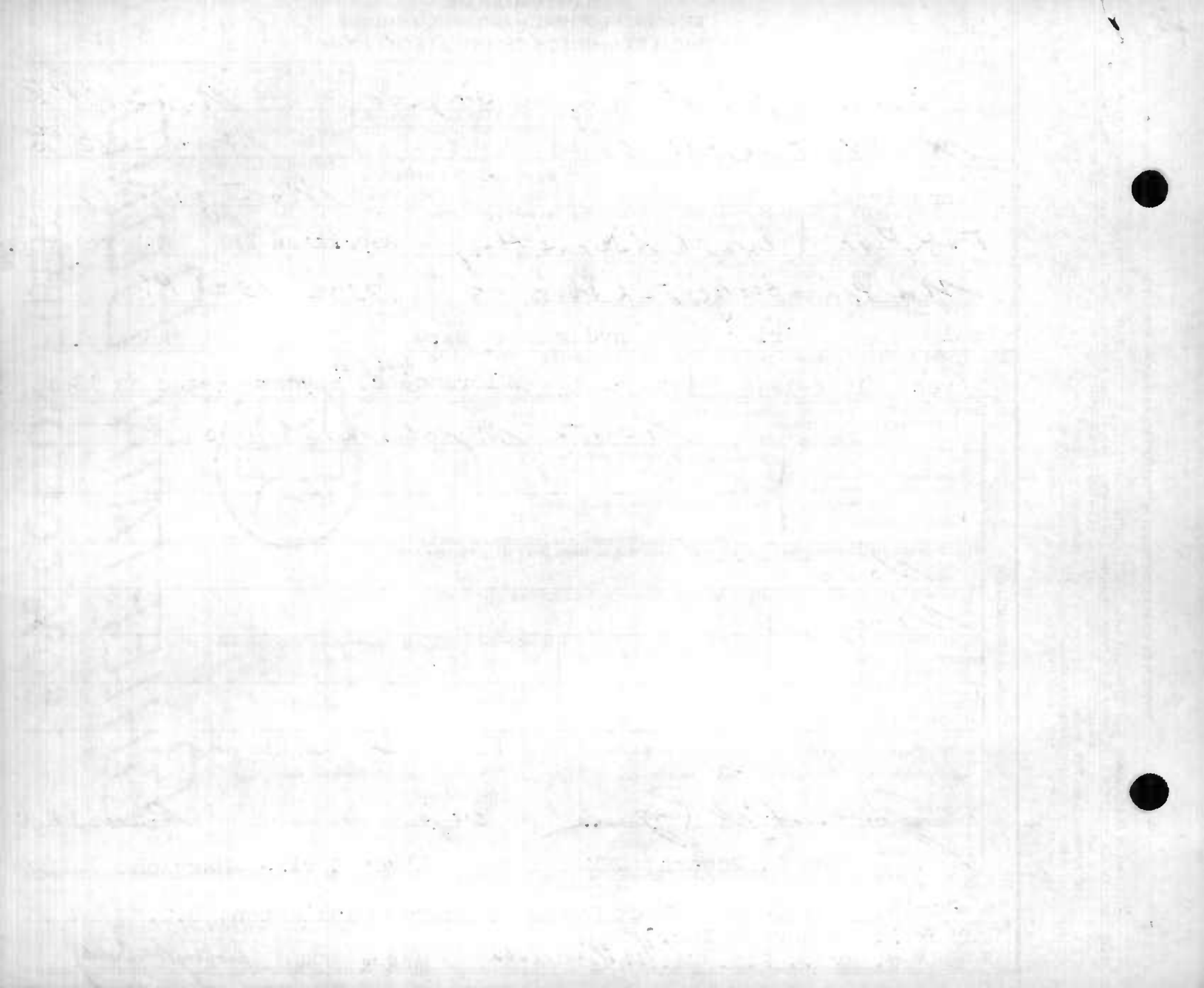
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR 1- STATE REGISTRAR		REG. NO. 08033								
1 DECEASED NAME (TYPE OR PRINT) Euberta D. Smith					2a. DATE OF DEATH MONTH DAY YEAR March 29 1980					2b. HOUR 1:30 P.M.
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 13 1897		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH S.S.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11550 Stewart Lane		
14 FATHER'S NAME FIRST MIDDLE LAST Burton Reid Smith					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Dickey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 056 52 7136		17 INFORMANT 1111 Copley Lane S.S.Md. JoAnn S. Alofs (Daughter)						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>4 YRS.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from <u>3/26</u> 19 <u>80</u> to <u>3/29</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>3/29</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.										
22b. SIGNATURE <u>R.T. Benack</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/29/80		
24 PHYSICIAN'S NAME (TYPE OR PRINT) R.T. Benack MD				22e. ADDRESS 4115 Colie Dr. Wheaton, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/1/80		23c. NAME OF CEMETERY OR CREMATORY Toga Point Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Athens, Pa.		25a. DATE REC'D. BY REGISTRAR APR 2 1980		
24 FUNERAL DIRECTOR NAME Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md.				450		25b. REGISTRAR'S SIGNATURE Pietro McCreedy				

BP



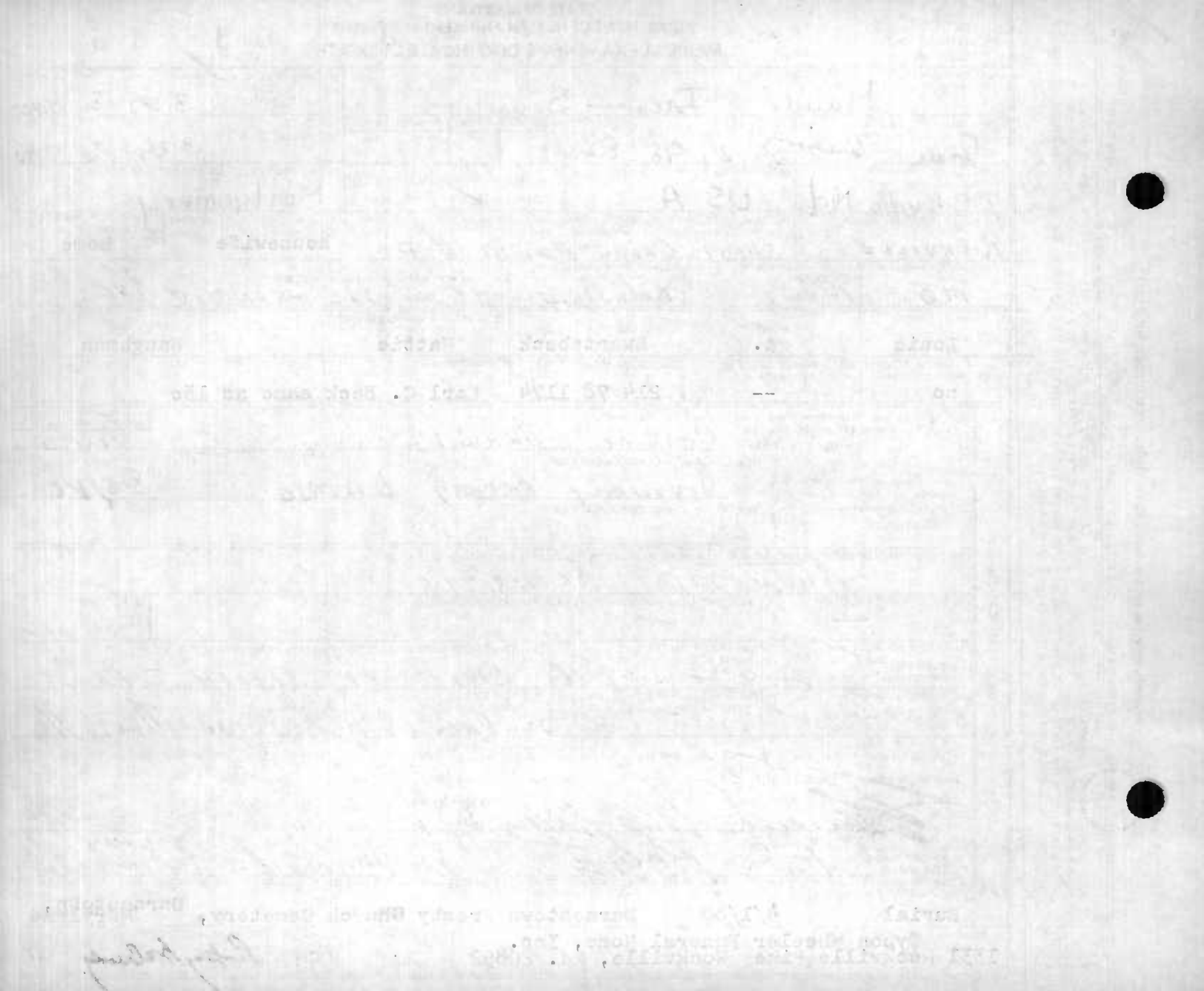
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										08034 REG. NO.			
1. DECEASED NAME FIRST MIDDLE LAST <i>John Robert t Thompson Snyder</i>										2a. DATE KNOWN OF DEATH MONTH DAY YEAR <i>March 2, 1980</i>		2b. HOUR OF DEATH MIN <i>1:25 PM</i>	
3. SEX <i>M</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>June 25 1963</i>		6. AGE (IN YRS) LAST BIRTHDAY <i>16 YRS</i>		IF UNDER 1 YR. MONTHS DAYS <i>0 0</i>		IF UNDER 24 HRS. HOURS MIN <i>0 0</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.				
10. CITY OR TOWN OF DEATH <i>Tak Park</i>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Wash Advent Hosp</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Repairman PBX</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>C&P Telephone Co.</i>				
13a. STATE <i>MD</i>				13b. COUNTY <i>Prince Georges</i>		13c. CITY OR TOWN <i>Tak Park</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>7302 15th Pl</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Paul Grier Snyder</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Shoenfelt</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>yes</i>				16b. SOCIAL SECURITY NO. <i>1944-1946 577-03-2628</i>		17. INFORMANT (wife) ADDRESS <i>Florence R. Snyder- (same as 13e)</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Div</i> 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>None</i>													
19a. DATE OF OPERATION <i>None</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>John S. Rogers</i>				TITLE (SPECIFY) M.D. <i>Dep</i>				MEDICAL EXAMINER DATE SIGNED <i>March 2, 1980</i>					
EXAMINER'S NAME (TYPE OR PRINT) <i>John S. Rogers, DME</i>				ADDRESS <i>Silver Spring, Maryland</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>3-5-80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington, D.C.</i>				
24. FUNERAL DIRECTOR <i>Wagner E. Pumphrey, Inc.</i>				ADDRESS <i>8434 Ga. Ave., S.S. Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>MAR 6 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Pistony/Kalinsky</i>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1- FOR STATE REGISTRAR		REG. NO. 08035											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH				2b. HOUR	
Maude Irene Saunders								ESTIMATED <input checked="" type="checkbox"/> 3 29 1980				0940 AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		7d. HOUR	
Female	Caucasian	04 29 98		82 YRS.						3 29 1980		0940 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Rockville, Md.		US A				Montgomery MD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rockville		SHADY GROVE ARTHRITIS HOP.								housewife		home	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MD		MONT.		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		322 GRANDIN AVE					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST				FIRST MIDDLE LAST									
Louis A. Swartzbeck				Hattie Baughman									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS					
no				214 78 1174				Earl C. Beck same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) CARDIAC ARREST												ACUTE	
4149 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.													
(b) CORONARY ARTERY DISEASE												8-10/VS	
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
RHUMATOID ARTHRITIS													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
9:40 PM				3 29 1980				SHORT OF BREATH & PAIN					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION					
								322 GRANDIN AVE ROCKVILLE MONT. MD					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion													
TITLES SPECIFY													
ACTUAL SIGNATURE												DATE SIGNED	
F. C. MAYER												3-29-80	
EXAMINER'S NAME (TYPE OR PRINT)												ADDRESS	
F. C. MAYER												8200 Wisconsin Ave Bethesda MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Burial		4/1/80		Darnestown Presby Church Cemetery,				Darnestown Maryland					
24. FUNERAL DIRECTOR								25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME 1331 Rockville Pike Rockville, Md. 20852								APR 3 1980		Ritony McCreedy			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 008036						
1. DECEASED NAME (TYPE OR PRINT) DOROTHY JEAN STANKEWICZ			2a. DATE OF DEATH MARCH 17, 1980			2b. HOUR 8:15 pm			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH February 7, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS		7. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE CLINICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Financial Ass't.		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
13a. STATE VIRGINIA			13b. CITY OR TOWN ALEXANDRIA		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 1018 PRISCILLA LANE 22308		
14. FATHER'S NAME John H. Campbell			15. MOTHER'S MAIDEN NAME Blanche B. Cooke			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16a. SOCIAL SECURITY NO. 577-30-1720			17. INFORMANT Mr. Richard Stankevicz			18. ADDRESS 15810 Presswick Lane Bowie, Md 20716			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) <u>Meningitis</u>									
2273 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>Cushing's Disease</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Pituitary adenoma</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION 3/12/80			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED pituitary adenoma			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (he) (this hospital) attended the deceased from <u>March 9</u> , 19 <u>80</u> , to <u>March 17</u> , 19 <u>80</u> , that (he) (we) lost (saw) the deceased alive on <u>March 17</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death.									
22a. SIGNATURE <u>Eugene A. Quindlen</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/18/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE A. QUINDLEN M.D.			22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MD 20205						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-21-80		23c. NAME OF CEMETERY OR CREMATORY Nat. Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia		
24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, Maryland			24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR MAR 24 1980		25b. REGISTRAR'S SIGNATURE <u>M. J. Brady</u>		

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17
(VR A15 ME (5))
15M/7/77

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 08037	
1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST						2b. DATE KNOWN OF DEATH ESTIMATED		2c. MONTH DAY YEAR	
		RUBY ETHEL STENGEL						MAR 3, 1980		5:50 PM	
3. SEX	4. RACE	5. DATE OF BIRTH (MONTH DAY YEAR)		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.		2d. DATE PRONOUNCED DEAD	
FEMALE	WHITE	JULY 28 1913		66 YRS.						mar 3, 1980 5:50 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
NORTH DAKOTA		USA				MONTGOMERY COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BETHESDA		CLINICAL CENTER, NIH BETH. MD				HOUSEWIFE		Home			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
WASHINGTON		PIERCE CO.		TACOMA				5404 S. M ST.			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
HENRY - IVERSON				ALICE - UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO				NONE		539-22-9574 MELVIN O. STENGEL (SAME AS PATIENT)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock & Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Retro Peritoneal Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Rupture Perforation Right Common Iliac Artery</u> 8706 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Mitral Stenosis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
March-3, 1980		Coronary Arteriogram.						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		A.M./P.M. 3-3 1980		Artery Catheter Perforated Iliac Artery							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
		Clinical Center		N.I.H.		Bethesda		Montgomery		MD	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE		TITLE (SPECIFY)				MEDICAL EXAMINER		DATE SIGNED			
JOHN G. BALL		M.D. Deputy						March 5, 1980			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
JOHN G. BALL		SILVER SPRING, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		MARCH 8, 1980		MOUNTAIN VIEW CEMETERY		TACOMA, PIERCE CO., WASHINGTON					
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTERED SIGNATURE							
CHAMBERS FUNERAL HOME SILVER SPRING, MD.		MAR 10 1980									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												08038 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Clement Ross Sterling, Jr.</i>												2a. DATE KNOWN OF DEATH MONTH DAY YEAR <i>3/28 1980</i>		2b. HOUR M <i>5:30</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Oct. 14, 1921</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>58</i>		IF UNDER 1 YR. MONTHS DAYS <i>0 0</i>		IF UNDER 24 HRS. HOURS MIN. <i>0 0</i>		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>3/28 1980</i>		2d. HOUR M <i>5:30</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>				7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County</i> MD.					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>2208 Linden Lane</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Self Employed</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Auto Parts</i>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>2208 Linden Lane</i>							
14. FATHER'S NAME FIRST MIDDLE LAST <i>Clement R. Sterling, Sr.</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lenora Summers</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>yes</i>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WW 11</i>		17. INFORMANT (wife) <i>Lorraine Sterling-</i>				ADDRESS <i>(same as 13e)</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART 1 DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <i>Metastatic carcinoma</i>															
DUE TO, OR AS A CONSEQUENCE OF															
(b) <i>carcinoma of the esophagus.</i>															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
<i>None</i>															
19a. DATE OF OPERATION <i>None</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>None</i>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <i>John S. Rogers, M.D.</i>				TITLE (SPECIFY) <i>Deputy</i>				MEDICAL EXAMINER <i>1919 Seminary Road Silver Spring, Montgomery, Md.</i>				DATE SIGNED <i>3/29/80</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>John S. Rogers, M.D.</i>				ADDRESS <i>1919 Seminary Road Silver Spring, Montgomery, Md.</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>4-1-1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Sil. Spr. Montgomery Md.</i>					
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>				ADDRESS <i>8434 Ga. Ave., S.S. Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>APR 3 1980</i>				25b. REGISTRAR'S SIGNATURE <i>Henry McBrady</i>			

Blank page with faint horizontal lines and two punch holes on the right side.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

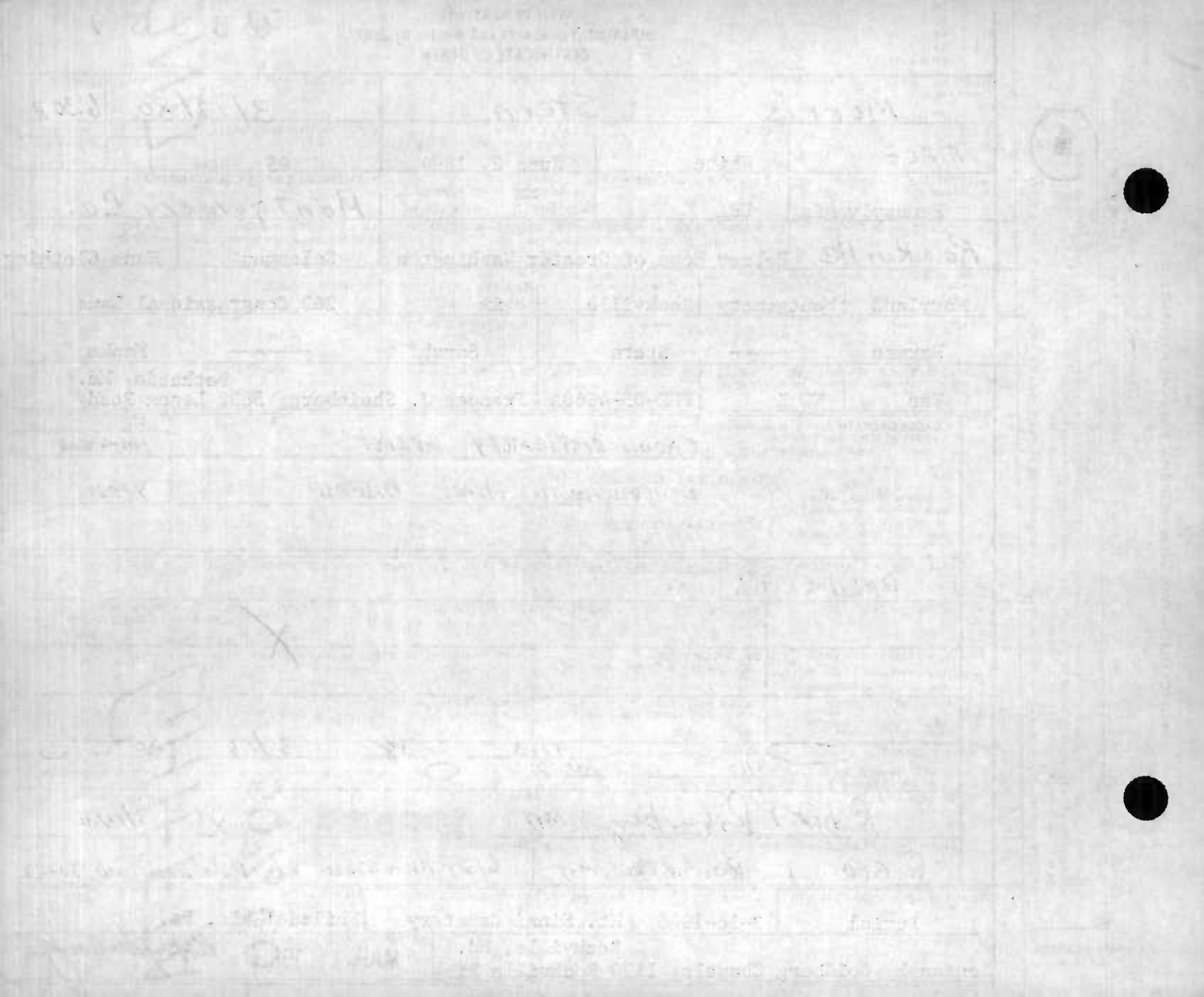
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Morris Stern			2a. DATE OF DEATH MONTH DAY YEAR 3/13/80		2b. HOUR 6:30 P.M.						
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 2, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater Washington				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Mens Clothing			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 263 Congressional Lane			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville							
14. FATHER'S NAME FIRST MIDDLE LAST Herman ----- Stern				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah ----- Manko							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WW I 182-05-4868A		17. INFORMANT ADDRESS Bethesda, Md. Frances J. Sheinberg; 5832 Lenox Road					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST 4140 DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONITIS Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MINUTE YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) PNEUMONITIS											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I (this hospital) attended the deceased from 9/13 , 19 78 , to 3/13 , 19 80 , that (I) (we) last saw the deceased alive on 3/13 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert L. Rosenberg MD				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 3/13/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT L. ROSENBERG, MD				22e. ADDRESS 6121 MONROSE RD, ROCKVILLE, MD. 20852							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-16-1980		23c. NAME OF CEMETERY OR CREMATORY Mt. Sinai Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Philadelphia, Pa.					
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike				ADDRESS Rockville, Md.		25a. DATE REC'D. BY REGISTRAR MAR 18 1980		25b. REGISTRAR'S SIGNATURE Robert L. Rosenberg			

0905
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										08040	
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH										2b. HOUR	
FIRST WILLIAM MIDDLE W. LAST STICKNEY <i>William W. Stickney</i>										MONTH <input type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR 1980 <i>3-1-1980</i>										3P <i>3P</i>	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR							
Male		White		MONTH May DAY 16 YEAR 1900		LAST BIRTHDAY 79 YRS.		MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>				MONTH March DAY 1 YEAR 1980		4P <i>4P</i>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				12b. KIND OF BUSINESS OR INDUSTRY					
New York				U.S.A.								Montgomery MD.				Officer (Ret) U.S. M.C.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)													
Bethesda				5201 Hampden Lane								Officer (Ret)									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS							
				Md.		Montgomery		Bethesda						5201 Hampden Lane							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																	
FIRST Henry MIDDLE Stickney LAST Stickney				FIRST Mary MIDDLE Sullivan LAST Sullivan																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS									
Yes				WW1 & WW2				215-38-7791				Jane L. Stickney, Wife. Same as item 13/									
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) Coronary Occlusion.																					
DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																					
(b) Cardio Vascular Disease																					
DUE TO, OR AS A CONSEQUENCE OF																					
(c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED March 2, 1980									
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D.				ADDRESS 7936 Old Georgetown Rd., Bethesda, Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3/6/1980				23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.				23d. LOCATION CITY OR TOWN Arlington, Virginia COUNTY STATE									
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc.				ADDRESS 5130 Wisc Ave., N.W. Wash., D.C.				25a. DATE REC'D. BY REGISTRAR MAR 5 1980				25b. REGISTRAR'S SIGNATURE Anthony McCreedy									

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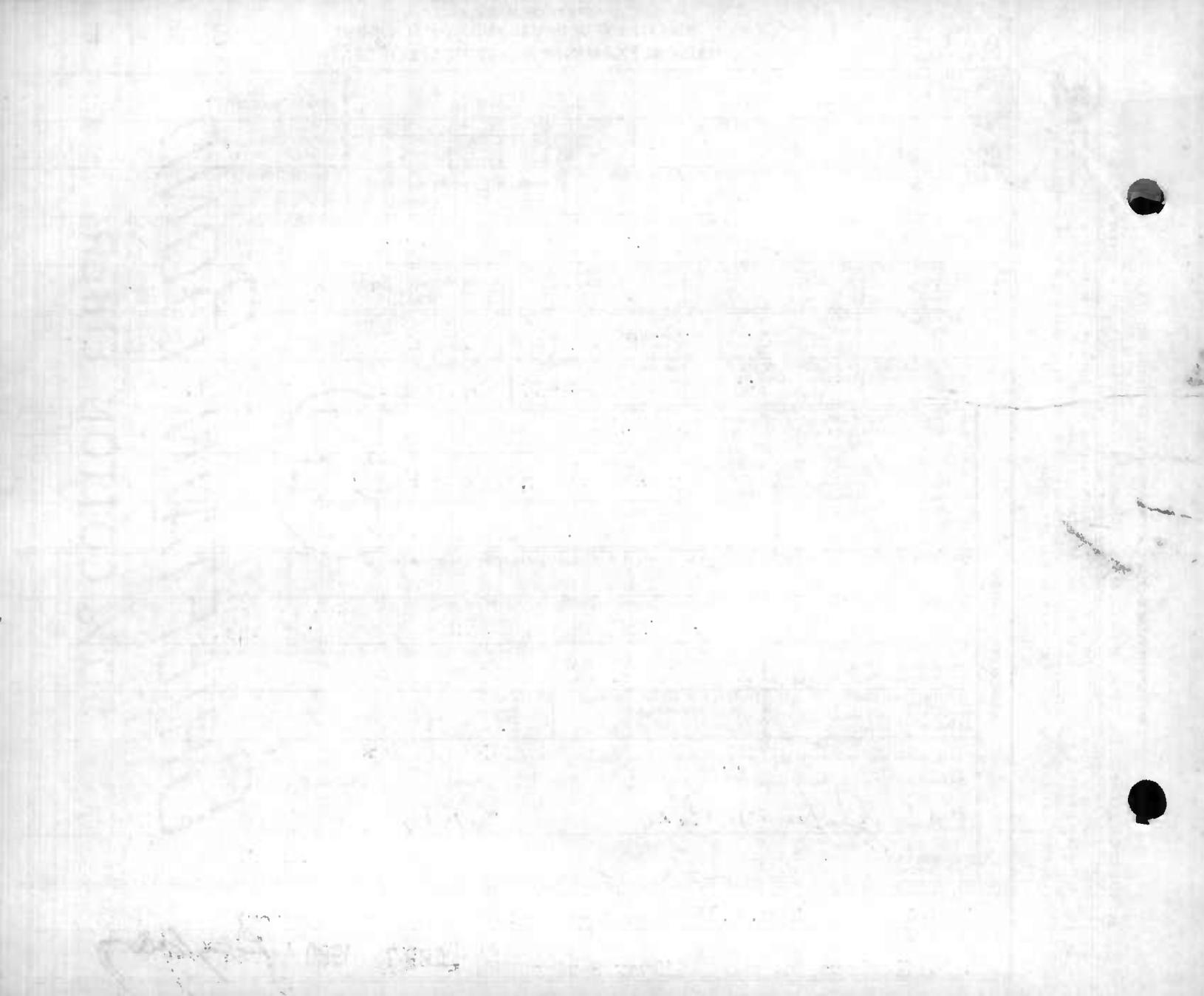
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 08041			
1. FOR STATE REGISTRAR										20. DATE KNOWN OF DEATH		21. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN EDWIN STONER, JR										20. DATE KNOWN OF DEATH ESTIMATED		21. HOUR	
2. SEX 3. RACE 4. DATE OF BIRTH (MONTH DAY YEAR) 5. AGE (IN YEARS LAST BIRTHDAY) 6. IF UNDER 1 YR. 7. IF UNDER 24 HRS. 8. MARRIED 9. NEVER MARRIED 10. WIDOWED 11. DIVORCED										20. DATE KNOWN OF DEATH ESTIMATED		21. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED 9. NEVER MARRIED 10. WIDOWED 11. DIVORCED										20. DATE KNOWN OF DEATH ESTIMATED		21. HOUR	
10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY										20. DATE KNOWN OF DEATH ESTIMATED		21. HOUR	
13. STATE 13a. CITY OR TOWN 13b. INSIDE CITY LIMITS? 13c. STREET ADDRESS										20. DATE KNOWN OF DEATH ESTIMATED		21. HOUR	
14. FATHER'S NAME 15. MOTHER'S MAIDEN NAME										20. DATE KNOWN OF DEATH ESTIMATED		21. HOUR	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS										20. DATE KNOWN OF DEATH ESTIMATED		21. HOUR	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2001 CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) LYMPHOCYTIC LYMPHOMA PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										20. DATE KNOWN OF DEATH ESTIMATED		21. HOUR	
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY?										20. DATE KNOWN OF DEATH ESTIMATED		21. HOUR	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 21b. TIME OF INJURY (HOUR MONTH DAY YEAR) 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										20. DATE KNOWN OF DEATH ESTIMATED		21. HOUR	
21d. INJURY OCCURRED WHILE AT WORK OR NOT WHILE AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)										20. DATE KNOWN OF DEATH ESTIMATED		21. HOUR	
22a. I certify that I took charge of the remains described above, held on Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner										20. DATE KNOWN OF DEATH ESTIMATED		21. HOUR	
ACTUAL SIGNATURE EXAMINER'S NAME (TYPE OR PRINT) ADDRESS										20. DATE KNOWN OF DEATH ESTIMATED		21. HOUR	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (CITY OR TOWN COUNTY STATE)										20. DATE KNOWN OF DEATH ESTIMATED		21. HOUR	
24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE										20. DATE KNOWN OF DEATH ESTIMATED		21. HOUR	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Thomas L. Styles			2a. DATE OF DEATH MONTH 3 DAY 6 YEAR 80			2b. HOUR 10⁴⁵ A.M.	
3. SEX male		4. RACE White		5. DATE OF BIRTH MONTH 7 DAY 14 YEAR 05		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY BUILDING CONTRACT	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY PR. GEO		13c. CITY OR TOWN TAKOMA PARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST THOMAS MIDDLE L. LAST STYLES		15. MOTHER'S MAIDEN NAME FIRST NET MIDDLE AVAILABLE LAST AVAILABLE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO NO		17. INFORMANT ADDRESS AGNES A STYLES 428 ETHAN ALLEN AVE T.P.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiac arrest**

4409

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **atrial fibrillation with**

DUE TO, OR AS A CONSEQUENCE OF

(c) **rapid ventricular response****arteriosclerosis**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

mitral regurgitation Pulmonary edema Hepatic hernia

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Jan 19 80 to 3-6 19 80 , that (I) (we) last saw the deceased alive on 3-5 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M SNOW MD				DEGREE MD		22c. DATE SIGNED 3.6.86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M SNOW MD				22e. ADDRESS 9013 FLOWER AVE SILVER SPRING MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 10, 1980		23c. NAME OF CEMETERY OR CREMATORY Edenwood Mem. Gardens		23d. LOCATION CITY OR TOWN Baltimoreville COUNTY MD STATE MD	
24. FUNERAL DIRECTOR NAME Arthur Walter ADDRESS 254 Carroll St N.W. Washington, DC 20002		25a. DATE REC'D. BY REGISTRAR MAR 10 1980		25b. REGISTRAR'S SIGNATURE Pitney McCreedy			

Handwritten text, possibly a signature or name, located in the upper left quadrant.

Handwritten text at the bottom of the page, possibly a date or reference number.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 0 8 0 4 3

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) James NELSON Sullivan			2a DATE OF DEATH MONTH DAY YEAR March 5 1980			2b HOUR 5:23 PM			
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 6 22 06		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10 CITY OR TOWN OF DEATH SILVER SPRING		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INSURANCE AGENT		12b KIND OF BUSINESS OR INDUSTRY PRUDENTIAL	
13a STATE MARYLAND			13b COUNTY MONTGOMERY		13c CITY OR TOWN SILVER SPRING		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST HARRY G. SULLIVAN			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PEARL BALDWIN			13e STREET ADDRESS 117 INDIAN SPRING DRIVE			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-09-9881		17 INFORMANT ADDRESS ANNE Y. SULLIVAN SAME AS 13 WIFE				
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 496- Possible pulmonary embolus DUE TO, OR AS A CONSEQUENCE OF (b) CHF DUE TO, OR AS A CONSEQUENCE OF (c) COVID-19 resp. failure								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Francis J. Collins						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 3/6/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Francis J. Collins						22e ADDRESS 10301 Georgia Ave SE, NE			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE 3/8/80		23c NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD.		
24 FUNERAL DIRECTOR'S NAME FRANCIS J. COLLINS						25a DATE REC'D. BY REGISTRAR MAR 10 1980		25b REGISTRAR'S SIGNATURE [Signature]	
26 ADDRESS 500 UNIV. BLVD., W. SILVER SPRING, MD. 20901									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

#16a, Film G544 6/10/80 kam

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 0 8 0 4 4

FOR
1- STATE
REGISTRAR

REG. NO.

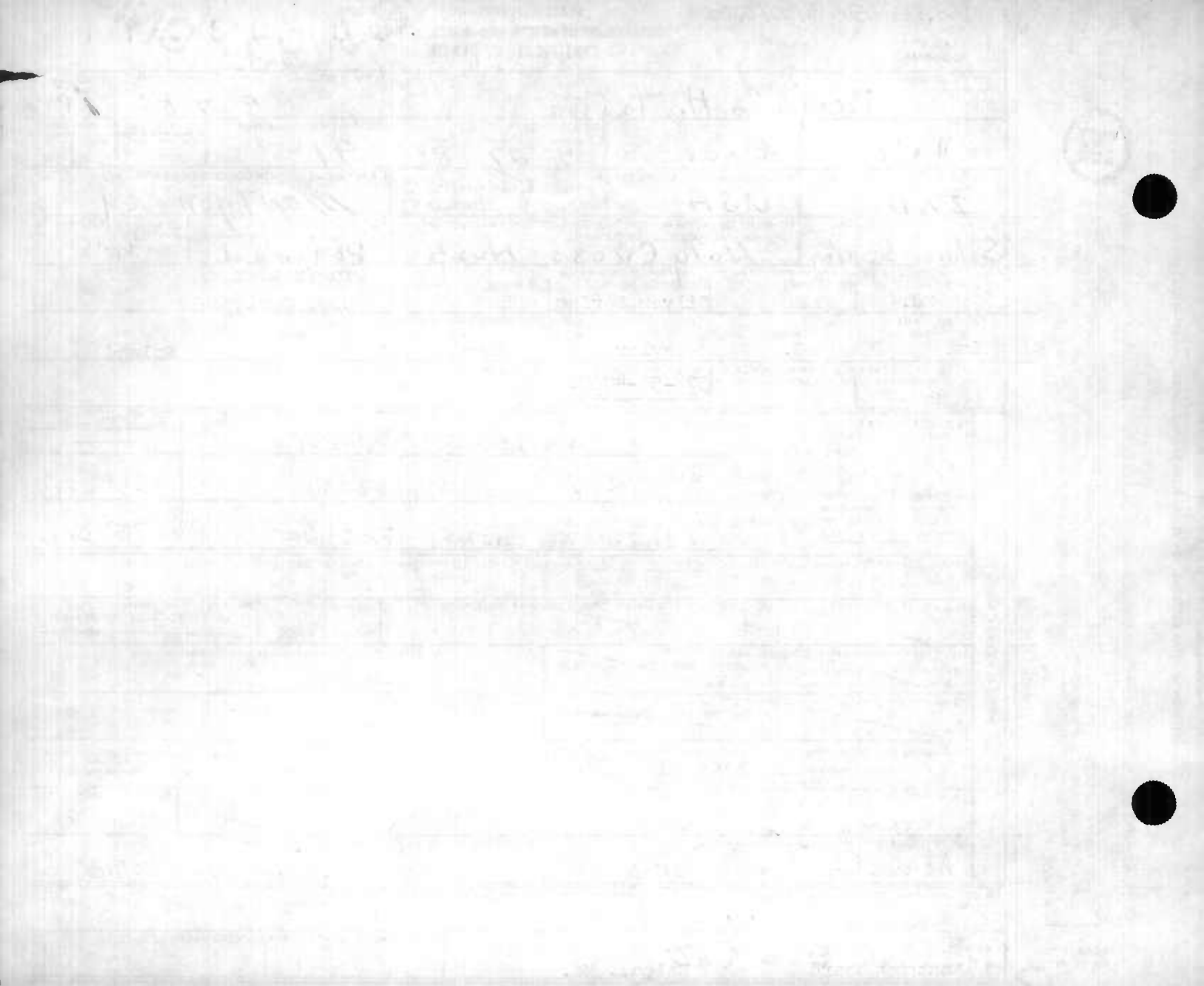
1. DECEASED NAME (TYPE OR PRINT) Benjamin H. Taylor			2a. DATE OF DEATH MONTH DAY YEAR 8 4 80			2b. HOUR P M P	
3. SEX Male	4. RACE Cauc	5. DATE OF BIRTH MONTH DAY YEAR 9 27 88		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Gov't	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Md.	13b. COUNTY Mont.	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 8505 Springdale			
14. FATHER'S NAME FIRST MIDDLE LAST Ira S. Taylor		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Roland					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-54-4060T 795-09-4123		17. INFORMANT ADDRESS			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4280 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC PULMONARY EDEMA	25 DAYS
	DUE TO, OR AS A CONSEQUENCE OF (c) CONGESTIVE HEART FAILURE	25 DAYS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from FEB. 5, 19 80, to MARCH 4, 19 80, that (I) (we) lost saw the deceased alive on MARCH 4, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Arnold G. Levy MD		DEGREE		22c. DATE SIGNED 3-4-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARNOLD G. LEVY, M.D.		22e. ADDRESS 1106 SPRING ST. SILVER SPRING, MD. 20910			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b. DATE 3/4/80	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.	
25a. DATE REC'D. BY REGISTRAR MAR 10 1980		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William Alexander TERRELL			2a. DATE OF DEATH MONTH DAY YEAR March 31 1980			2b. HOUR 5:15P M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 31 1980		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 42 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A	
12b. KIND OF BUSINESS OR INDUSTRY -		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland					
13c. COUNTY Pr. George		13d. CITY OR TOWN New Carrollton		13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS 6103 Westbrook Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Daryl B. Terrell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary K. Dixon			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT ADDRESS Daryl B. Terrell See item 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) No Respiratory 7651 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Secondary to prematurity Prematurity 24 wks DUE TO, OR AS A CONSEQUENCE OF (c) -							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (a) (this hospital) attended the deceased from 4:56 PM Mar 31, 1980 to 5:15 PM Mar 31, 1980 , that (b) (we) lost saw the deceased alive on above, (c) (we) (did) (did not) view the body after death.							
22b. SIGNATURE LTC J CONLON MC USNR				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED April 1, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LTC J CONLON MC USNR				22e. ADDRESS National Naval Medical Center, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/3/1980		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Nalley's Funeral Home Mt. Ranier, Md.				25a. DATE REC'D. BY REGISTRAR APR 7 1980		25b. REGISTRAR'S SIGNATURE Victory McCreedy	

BP

3605



11/1/11

ALMA 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										0 8 0 4 6	
1. FOR STATE REGISTRAR			REG. NO.								
1 DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR					
Eleanor Laurie Thebaud			3-8-80/3-8-80			11:45 AM					
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7a. MONTHS		7b. DAYS	
Female		Caucasian		5 5 99		80 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania		USA				Montgomery County, MD					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Rockville		Collingswood N.H.				Homemaker		Home			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Maryland			Montg.		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		299 Hurley Avenue		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
E. S. McCawley			Mary Belle Smith								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17 INFORMANT					
No			579-40-3099			33 ADDRESS Rosemont Avenue Diana Nicholson, Montreal, Quebec, Canada					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Cardiac Arrest											
4275											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) Unknown											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Chronic Congestive Heart Failure											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
			HOUR A.M. MONTH DAY YEAR								
			P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION						
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 2/8/80 to 3/8/80, that (I) (we) last saw the deceased alive on 2/22/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			22c. DATE SIGNED					
Robert A. Hallowitz			M.D.			3/8/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
Robert A. Hallowitz			11119 Rockville Pike, Rockville, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY		
Cremation			3-9-80		Metropolitan Crem.		Alexandria, Virginia		STATE		
24 FUNERAL DIRECTOR NAME			24b. ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
ROBERT A. PUMPHREY FUNERAL HOMES, P. A., Bethesda, Maryland						MAR 11 1980			Hirshy McCready		

17

Handwritten notes and markings, including "A-1" and "A-2".

Handwritten text: "The following..."

Handwritten notes and markings, including "A-1" and "A-2".

1980 MAR -4 PM 12:59

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 0 0 8 0 4 7							
1. DECEASED NAME (TYPE OR PRINT) Charles H. Thomas					2a. DATE OF DEATH MONTH 3 DAY 4 YEAR 80			2b. HOUR 136A M	
3. SEX M		4. RACE Black		5. DATE OF BIRTH MONTH 3 DAY 20 YEAR 20		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS		7. IF UNDER 1 YEAR MONTHS 59 DAYS 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY Monty Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13a. COUNTY Mont.		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 17053 Claridge Rd.			
14. FATHER'S NAME FIRST Marshall MIDDLE Thomas LAST Thomas					15. MOTHER'S MAIDEN NAME FIRST Virginia MIDDLE Frazier LAST Frazier				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 216-22-0377		17. INFORMANT ADDRESS Adella Thomas (wife) Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia w/ Gram negative sepsis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
2028 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) perforated Ulcer								10 days	
DUE TO, OR AS A CONSEQUENCE OF (c) Malignant Lymphoma								>4 months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Bronchopneumonia, Disseminated Intravascular Coagulation, Renal failure									
19a. DATE OF OPERATION 2/17/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED perforated Ulcer				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1/25 19 80 , to 3/4 19 80 , that (I) (we) last saw the deceased alive on 3/4 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Peter B. Sherer MD				DEGREE MD				22c. DATE SIGNED 3/6/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER B. SHERER MD				22e. ADDRESS 6410 Rockledge Dr. #208 Bethesda, Md. 20034					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-8-80		23c. NAME OF CEMETERY OR CREMATORY Ash Memorial Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Sandy Spring Monty Md.			
24. FUNERAL DIRECTOR NAME George R. Snowden ADDRESS 246 N. Washington ST. Rockville, Md.									

1. The first of these is the fact that the
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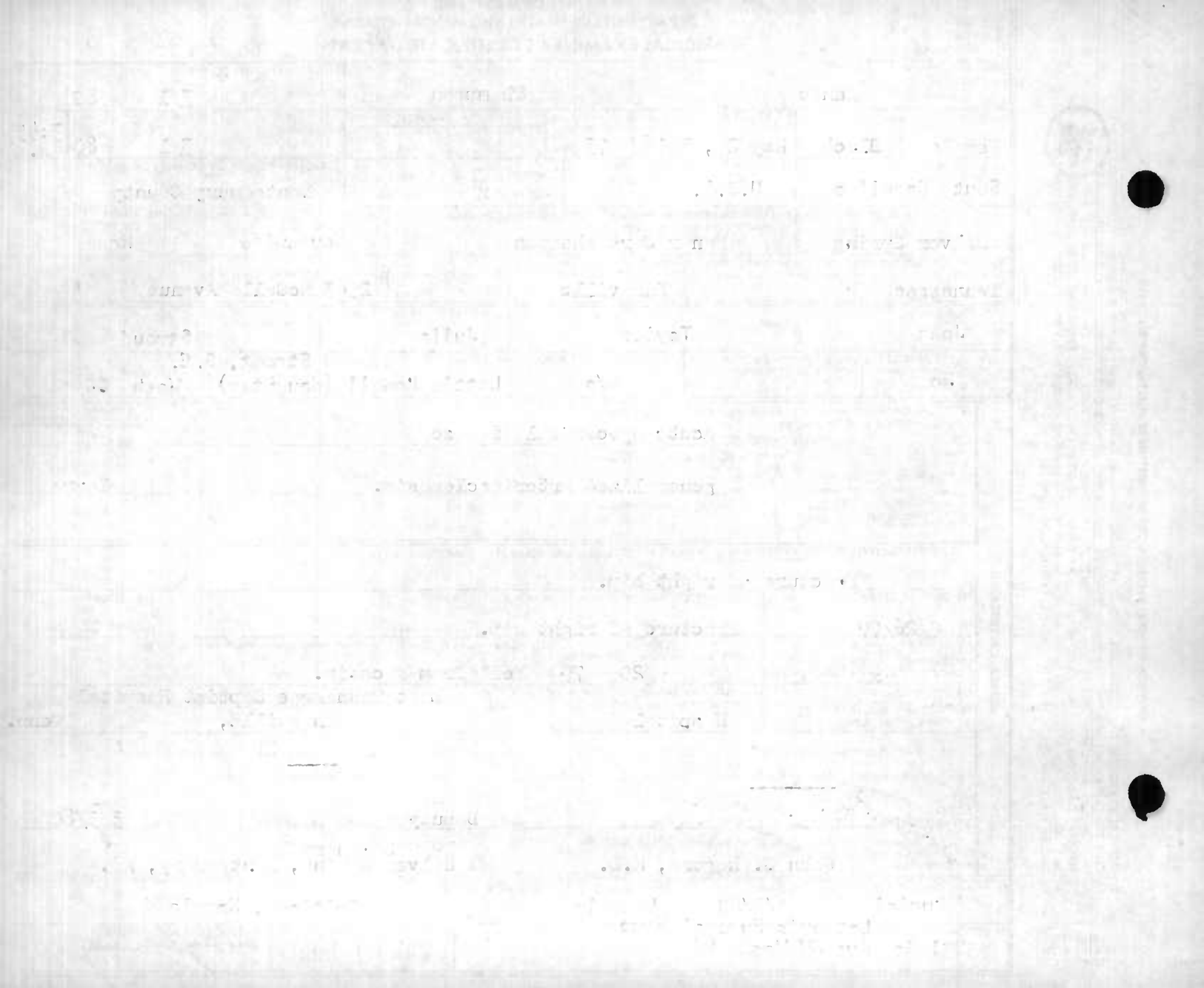
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 15 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 08048

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 3/1 19 80										2b. HOUR OF DEATH 3:45 A.M.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. HOUR OF DEATH 3:45 A.M.							
Annie						Thompson									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR OF DEATH 3:45 A.M.	
Female		Black		May 20, 1906		73 YRS.						3/1 19 80			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
South Carolina		U.S.A.				Montgomery County MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Silver Spring		Manor Care Wheaton		Housewife		None									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS							
Tennessee		Knoxville		Knoxville				2503 McCalla Avenue							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
John Taylor				Julia Stroud											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT							
No				n/a				4645 H Street, S.E. Lettie Howell (daughter) Wash. DC							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u>															
DUE TO, OR AS A CONSEQUENCE OF															
(b) <u>generalized arteriosclerosis.</u>															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
<u>Fracture of right hip.</u>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
9/26/79				Fracture of right hip.				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 9/20 1979				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
								Fell from a chair.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
				Hospital				East Tennessee Baptist Hospital Knoxville, Tenn.							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
John S. Rogers, M.D.				Deputy				3/3/80							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
John S. Rogers, M.D.				1919 Seminary Road Silver Spring, Montgomery, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
Burial				3/7/80		Lincoln		Suitland, Maryland							
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Latney's Funeral Home				MAR 10 1980				[Signature]							
3831 Ga. Ave NW Wash. DC															



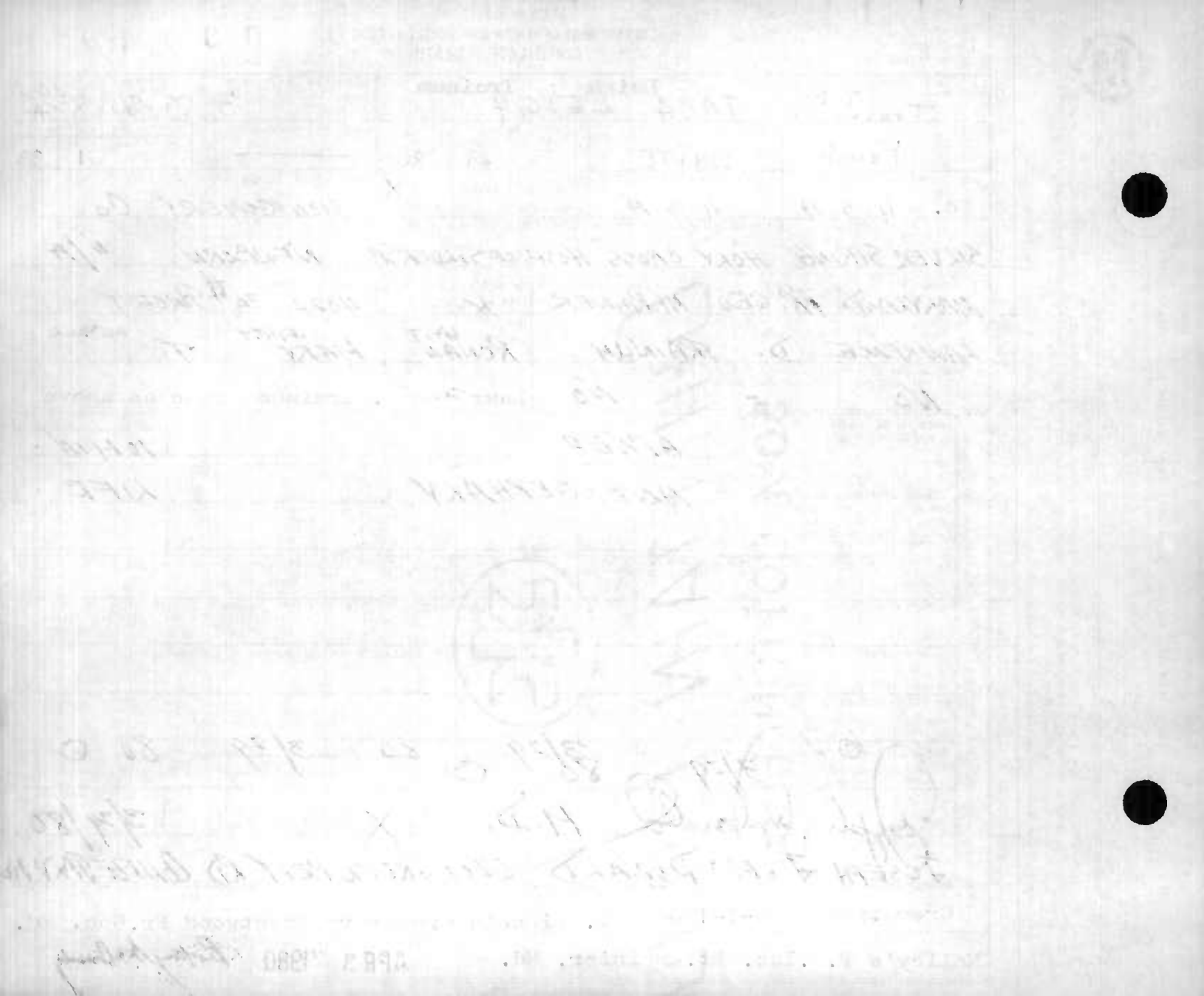


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 08049				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Tara Leigh Trainum TARA LEIGH					2a. DATE OF DEATH MONTH DAY YEAR 3 29 80				
3 SEX Female		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 3 29 80		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 1 33		7b. HOUR 8:50 AM	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. U.S.A		7b CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY Co MD.			
10 CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSP OF SILVER SPR				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NEWBORN		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. STATE MARYLAND		13b. CITY OR TOWN PR. GEO		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4622 36th STREET			
14 FATHER'S NAME FIRST MIDDLE LAST LAWRENCE D. TRAINUM		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RONAN, MARY T.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. -		17 INFORMANT ADDRESS Lawrence D. Trainum Same as above					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) APNEA 7400 DUE TO, OR AS A CONSEQUENCE OF (b) ANENCEPHALY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MIN. LIFE									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
21g. I certify that (1) this hospital attended the deceased from 3/29 1980 to 3/29 1980, that (2) we lost the deceased alive on 3/29 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (3) we did not use the body after death.									
22a. SIGNATURE Joseph F. McDonald M.D.					22b. DATE SIGNED 3/29/80				
22c. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH F. MCDONALD					22d. ADDRESS 6201 GREENBELT RD. BALE PARK MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 4-1-1980		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Nalley's F.H. Inc. Mt. Rainier, Md.					25a. DATE REC'D. BY REGISTRAR APR 3 1980		25b. REGISTRAR'S SIGNATURE Dorothy McCreedy		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical-examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 08050

1. FOR
STATE
REGISTRAR

Edmund J

1. DECEASED NAME (TYPE OR PRINT) Edmund J Twohig		2a. DATE OF DEATH MONTH DAY YEAR 3/18/80		2b. HOUR 11²⁵ A M	
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 8 25 21	6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10 CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TECHNICIAN U.S. NAVAL ORD LAB		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 9818 COTTRELL TERRACE	
14 FATHER'S NAME FIRST MIDDLE LAST EDMUND J. TWOHIG		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERTRUDE MAGEE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 025-12-4124		17 INFORMANT ADDRESS MARY P. TWOHIG SAME AS 13 WIFE	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 410- Myocardial Infarction IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last General Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF 10 days 10 years 10 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Duodenal Ulcer, Diabetes					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/8 , 19 80 , to 3/18 , 19 80 , that (I) (we) last saw the deceased alive on 3/18/80 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Keith Lindgren MD		DEGREE MD		22c. DATE SIGNED 3/18/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KEITH LINDGREN		22e. ADDRESS 7600 CARROLL AVENUE, TAKOMA PARK, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/21/80		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN	
23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.		24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		25a. DATE REC'D. BY REGISTRAR MAR 21 1980	
25b. REGISTRAR'S SIGNATURE Patricia Kennedy		25c. ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901			

"ZIGZAG"

4214-27-250

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the health officer. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					REG. NO. 08051				
1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Julia</u> MIDDLE <u>---</u> LAST <u>Tyser</u>					2a. DATE OF DEATH MONTH <u>3</u> DAY <u>14</u> YEAR <u>80</u> 2b. HOUR <u>1135AM</u>				
3 SEX <u>FEMALE</u>		4 RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH <u>9</u> DAY <u>12</u> YEAR <u>1895</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>84</u> YRS		IF UNDER 1 YEAR MONTHS <u>---</u> DAYS <u>---</u> HOURS <u>---</u> MIN. <u>---</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Baltimore, Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.			
10. CITY OR TOWN OF DEATH <u>ROCKVILLE</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>HEBREW HOME OF GREATER WASHINGTON</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
13a. STATE <u>---</u>		13b. COUNTY <u>---</u>		13c. CITY OR TOWN <u>Washington, DC</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>2939 Van Ness Street, N.W.</u>	
14. FATHER'S NAME FIRST <u>Jesse</u> MIDDLE <u>---</u> LAST <u>Caplan</u>					15. MOTHER'S MAIDEN NAME FIRST <u>Ninnie</u> MIDDLE <u>---</u> LAST <u>Leavitt</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>					16b. SOCIAL SECURITY NO. <u>218-05-6781-B</u>		17. INFORMANT ADDRESS <u>Ralph J. Tyser, 2801 N.M. Ave., NW, Wash., D.C.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>4140</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ATHEROSCLEROTIC HEART DISEASE</u> (c) <u>YEARS</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>ORGANIC BRAIN SYNDROME</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR <u>---</u> A.M. MONTH <u>---</u> DAY <u>---</u> YEAR <u>19</u> P.M. <u>---</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <u>---</u> CITY OR TOWN <u>---</u> COUNTY <u>---</u> STATE <u>---</u>			
22a. I certify that (1) (this hospital) attended the deceased from <u>3/1/80</u> to <u>3/1/80</u> , that (1) (we) lost above, (1) (we) did not view the body after death.									
22b. SIGNATURE <u>Robert L. Rosenberg, MD</u>					DEGREE <u>---</u>		22c. DATE SIGNED <u>3/1/80</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ROBERT L. ROSENBERG, MD</u>					22e. ADDRESS <u>6121 MONTPEL RD, ROCKVILLE, MD.</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>3/18/80</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship Cem.</u>		23d. LOCATION CITY OR TOWN <u>Baltimore, Maryland</u> STATE <u>---</u>		
24. FUNERAL DIRECTOR NAME <u>Joseph Gawler's Sns, Inc., Washington, DC 20016</u>					25a. DATE REC'D. BY REGISTRAR <u>MAR 19 1980</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO. 008052			
1- FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wen Chung Tzu				2a. DATE OF DEATH MONTH DAY YEAR March 4, 1980		2b. HOUR 6:30am	
3. SEX Male		4. RACE Chinese		5. DATE OF BIRTH MONTH DAY YEAR 10/16/1958		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 21	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) China		7b. CITIZEN OF WHAT COUNTRY? China		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Clinical Center, NIH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY SCHOOL	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Taipei-Taiwan		13c. CITY OR TOWN Taipei, Taiwan		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 132 Dar-Le Street	
14. FATHER'S NAME FIRST MIDDLE LAST Yen		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Yuen Chang Tsao					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS Yen Tzu (FATHER) Same AS #13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Widespread abdominal sarcoma</u> <u>1715</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal failure</u> Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral edema</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>September 21, 79</u> to <u>March 4, 80</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>March 4, 1980</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.							
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/4/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Baron Kirkemo MD				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE MARCH 5, 1980		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND, P.G.-CO., MARYLAND	
24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME - SILVER SPRING, MD.				25a. DATE REC'D. BY REGISTRAR MAR 10 1980		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 0 0 8 0 5 3									
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Humberto NMN) Valenzuela								March 29, 1980		8:45 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
Male		White		June 29, 1945		34					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Chile		USA				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		The Clinical Center, NIH						Manager		Restaurant	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. COUNTY		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS			
New York		Queens		Bayside				61-62A 223rd Place			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Humberto -- Valenzuela		(Unknown)									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No --		108-48-4491		Geraldine Valenzuela, wife Same							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>gastrointestinal bleeding</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
2002 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Burkitt's lymphoma</u>										12 hours	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>6 February 19 80</u> to <u>29 March 19 80</u> , that <input checked="" type="checkbox"/> (we) lost <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (we) did not view the body after death.											
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
Carol Janus, MD				3/29/80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
CAROL JANUS, MD		The Clinical Center, National Institutes of Health, Bethesda, Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Removal		3/29/80				Bronx New York					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Chambers Funeral Home-Silver Spring, Md.				APR 7 1980		[Signature]					

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part of the [unintelligible]
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to the [unintelligible]
of the [unintelligible]

1980 1980 1980
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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

08054

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Garret Morgan Van Hoesen			2a. DATE OF DEATH MONTH DAY YEAR 03 16 80		2b. HOUR 9:30P
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Oct. 18, 1899		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Internal Rev. Ser. U.S. Gov't.	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Finley Morris Van Hoesen			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Belle Skeel Morgan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-12-4618		17 INFORMANT ADDRESS Lillian G. Van Hoesen Same as # 13 Item	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest 436- DUE TO, OR AS A CONSEQUENCE OF (b) CVA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) cardiovascular insufficiency					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immed 6 wks yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/9/80 , 19____, to 3/16/80 , 19____, that (I) (we) last saw the deceased alive on 3/14/80 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert Millman, MD			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/17/80
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Millman, MD			22e. ADDRESS 15E Deer Park Dr Gaithersburg Md 20878		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/18/80	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md.
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash., D.C. 20016			25a. DATE REC'D. BY REGISTRAR MAR 21 1980		25b. REGISTRAR'S SIGNATURE Dorothy McBrady

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 08055	
1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HUGH ALBERT VOIGHT										MONTH DAY YEAR 03/25 1980	
3. SEX Male										2b. HOUR MINUTE	
4. RACE white										2c. DATE PRONOUNCED DEAD	
5. DATE OF BIRTH 16, 1918										MONTH DAY YEAR 03/25 1980	
6. PLACE OF BIRTH										2d. TIME	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia										2e. BALTIMORE CITY OR COUNTY OF DEATH	
7b. CITIZEN OF WHAT COUNTRY? USA										Montgomery County MD	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
10. CITY OR TOWN OF DEATH Olney										Body-Fender Rep.	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital										12b. KIND OF BUSINESS OR INDUSTRY Automotive	
13a. STATE Md										12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 5225 Damascus Rd.	
13b. COUNTY Mont										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13c. CITY OR TOWN Laytonsville										13e. STREET ADDRESS 5225 Damascus Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Leslie C. Voight										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Marie Brown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes										16b. SOCIAL SECURITY NO. 227-12-7288	
16c. IF YES, GIVE WAR OR DATES WWII										17. INFORMANT ADDRESS Jean A. Voight Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Chronic Myocardial Dis.</u> (c) <u>None</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yr	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>None</u>											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>										21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21c. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John S. Rogers</u> M.D. <u>Rep.</u> MEDICAL EXAMINER										DATE SIGNED <u>March 25, 1980</u>	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers										ADDRESS Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE <u>March 28, 1980</u>	
23c. NAME OF CEMETERY OR CREMATORY Cheltenham Cemetery										23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Prince Geo. Md.	
24. FUNERAL DIRECTOR NAME FRANCIS H. BARBER										25a. DATE REC'D. BY REGISTRAR	
ADDRESS LAYTONSVILLE, MD. 20760										25b. REGISTRAR'S SIGNATURE <u>History Kelly</u>	

MAR 28 1980

TO: *Mr. J. H. ...*
FROM: *Mr. ...*
SUBJECT: *...*

Enclosed for your information are the following:

- 1. *...*
- 2. *...*
- 3. *...*

Very respectfully,
...

...

...

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BP

DHMM - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 08056	
1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
		Josie Livona Waskey				March 11, 1980				1:05a M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		March 25, 1897		82		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Washington		USA				Montgomery County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Olney		Montgomery General Hospital				Teacher		Education			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Mont.		Olney		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18201 Marden Lane			
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME							
John F. MOODY				Hattie - Lufkin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS					
no		567-28-5648A		Roberta W. Howe		Same as # 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Acute coronary Disease										Hours	
410- DUE TO, OR AS A CONSEQUENCE OF											
(b) Chronic ASCVD										Years	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION							
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
J. Minarcik								3/11/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
M. Bolognese, M.D. J. Minarcik, MD				18101 Prince Philip Drive Olney, Maryland 20832							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		STATE			
Burial		March 12, 1980		Laytonsville		Laytonsville		Mont. Md.			
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
FRANCIS H. BARBER FUNERAL HOME LAYTONSVILLE MD. 20760						MAR 14 1980		[Signature]			

MEDICAL CERTIFICATION

14

DO NOT

GO IN

THE



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BP

DHMM-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

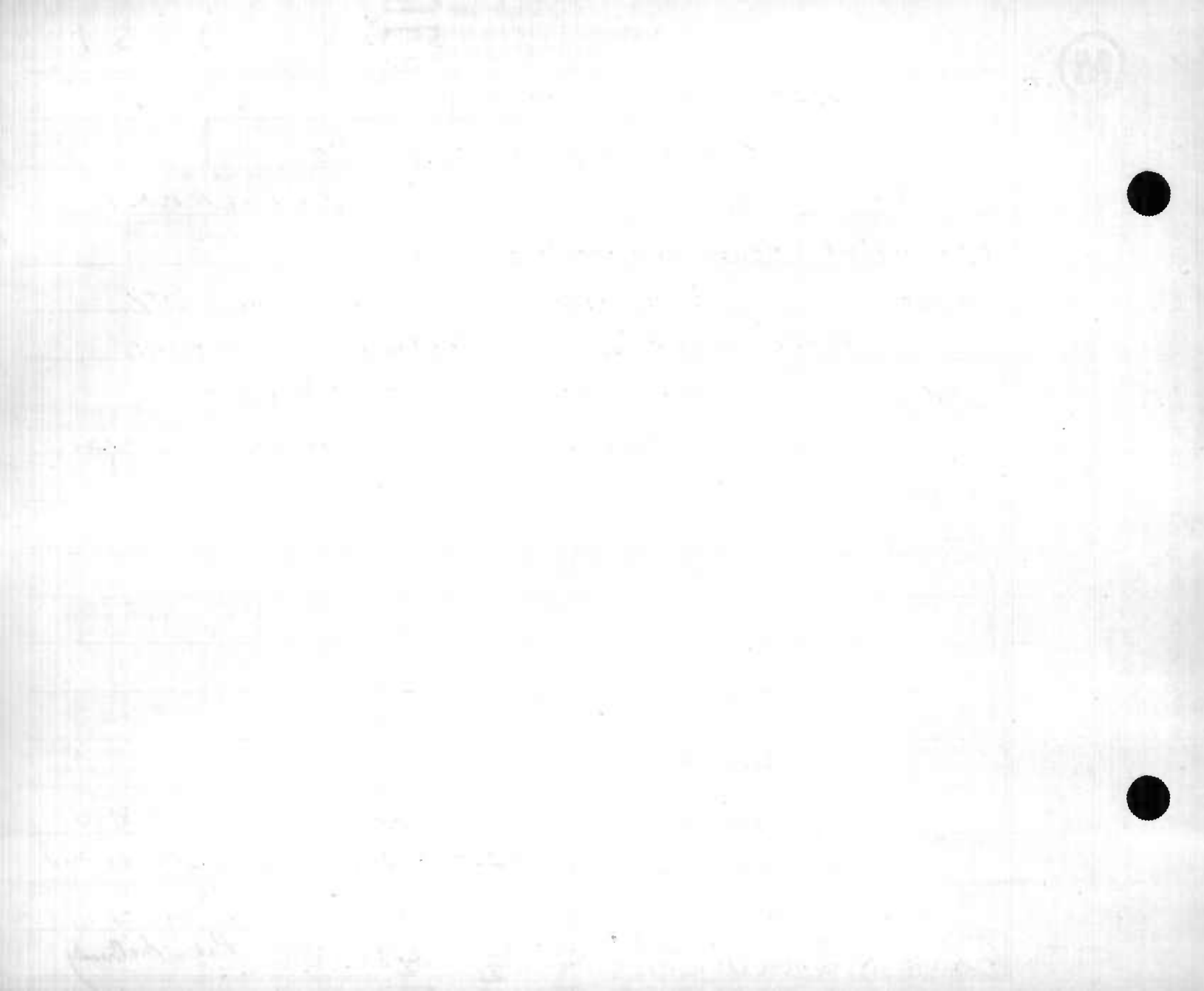
REG. NO.

0 0 8 0 5 7

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) LELIA		FIRST —		MIDDLE —		LAST WATKIN		2a. DATE OF DEATH MONTH DAY YEAR 3 8 80		2b. HOUR M	
3 SEX Female		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR APR. 18, 1889		6 AGE (IN YEARS LAST BIRTHDAY) 90		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY				MD.	
10 CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Gardens Nursing		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Benton Harbor		13c. CITY OR TOWN Benton Harbor		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 627 VUSS ST.			
14. FATHER'S NAME FIRST MIDDLE LAST Peter Watkins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Goldman Watkins									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OF UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 344-22-5610		17. INFORMANT ADDRESS Nursing Home Records-							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Terminal cerebral thrombosis 4340 DUE TO, OR AS A CONSEQUENCE OF (b) — DUE TO, OR AS A CONSEQUENCE OF (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 1977		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 3/8/80, 19____, that (I) (we) last saw the deceased alive on Feb 19 80, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature]				DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN				22c. DATE SIGNED 3/8/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OSOTH LEXAGUL MD				22e. ADDRESS 7450 arlington rd Bethesda Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-7-80		23c. NAME OF CEMETERY OR CREMATORY Monty Co. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.					
24. FUNERAL DIRECTOR NAME George R. Snowden				24b. ADDRESS 246 N. Wash. St. Rockville, Md.		25a. DATE REC'D. BY REGISTRAR APR 7 1980		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION



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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

65008058

1. DECEASED NAME (TYPE OR PRINT) Adelaide H. Webb			2a. DATE OF DEATH MONTH DAY YEAR March 16 1980			2b. HOUR 4:50 PM	
3. SEX Female		4. RACE black white		5. DATE OF BIRTH MONTH DAY YEAR Mar. 4 th 1898		6. AGE (IN YEARS LAST BIRTHDAY) 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Gardens Nur. Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY own home							
13a. STATE Maryland			13b. CITY OR TOWN Montgomery			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ezra J. Horine			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Augusta Adelaide (unknown)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none			17. INFORMANT (daughter) ADDRESS 219-64-3798 Miriam W. Kilb- (same as 13e)	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coughing - Septicemic Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Septicemic Pneumonia</u> (c) <u>Septicemic Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Chronic Cardiovascular Disease</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>March 13, 1980</u> to <u>March 16, 1980</u> , that (I) (we) last saw the deceased <u>March 14, 1980</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Benton M. Hreniwinski, MD.</u>		22c. DATE SIGNED 3-17-80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Benton M. Hreniwinski, MD.		22e. ADDRESS 3720 Fairview Ave. N.W., Md. 20795					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-21-1980		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.	
24. FUNERAL DIRECTOR NAME Warner P. Pumphrey, Inc.				24b. ADDRESS 8434 Ga. Ave., S.S. Md.		25a. DATE REC'D. BY REGISTRAR MAR 20 1980	
				25b. REGISTRAR'S SIGNATURE <u>Patricia McCready</u>			

MD



MEPTO

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMM-17
(VR A15 ME (5))
30M 7/73

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR		REG. NO. 08059									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR	
GEORGE F. WEBB, Jr.								MONTH DAY YEAR		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD	
male	black	MONTH DAY YEAR		MONTHS DAYS HOURS MIN.						MONTH DAY YEAR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				5:30 P.M.	
Md.		U.S.A.				Howard County				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Laurel		All Saints Rd 9325		Custodian							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.		Pr. Geo		Laurel		YES <input type="checkbox"/> NO <input type="checkbox"/>		9311 All Saints Road			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
George Webb, Sr.		Surella W. Bishop		No				George Webb (Father)		3547 Whiskey Bottom Rd. Laurel, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY: Gunshot wound to back											
IMMEDIATE CAUSE (a) 9654											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?							
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		5:20 P.M. 3-30 1980		subject shot							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION							
		street		9325 All Sts. Rd. Laurel, Maryland							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED							
Margarita A. Korell		M.D. Assistant		3-31-80							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		4-5-80		Ash Memorial Cemetery		Sandy Spring, Montg.		Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. RECEIVED BY					
George R. Snowden		246 N. Washington Street Rockville, Md. 20850		APR 7 1980							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMM - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 0 0 8 0 6 0							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CAROLINE S. WEINBERG					2a. DATE OF DEATH MONTH DAY YEAR 3 7 80			2b. HOUR 9:15PM _M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 17 27		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Olney					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3224 Sparton Road,		
14. FATHER'S NAME FIRST MIDDLE LAST (unknown)					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth E. Stitt				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none		17. INFORMANT (husband) ADDRESS Joseph Weinberg- (same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, 18c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Failure</i> 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF <i>Carcinoma of Pancreas - Prostatectomy</i> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month 8 months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 3/1 19 80 to 3/8 19 80, that (I) (we) lost saw the deceased alive on 3/7/80 19 80, and that injury (our opinion) death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Dennis R. Schomer</i> MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/8/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dennis R. Schomer					22e. ADDRESS 17904 Bearsse Ave 216 Olney, Md 20832				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-10-80		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Georges Md.			
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.					25a. DATE REC'D. BY REGISTRAR MAR 12 1980		25b. REGISTRAR'S SIGNATURE <i>Robert M. McLean</i>		

MEDICAL CERTIFICATION

2
9

1301 BP

MARK 12 1980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1, 2, and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, this medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 08061							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edith Wells.						2a. DATE OF DEATH MONTH DAY YEAR 22 Mar 80		2b. HOUR 3:10 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 21, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md		13b. COUNTY Pro George		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6305 47th avenue	
14. FATHER'S NAME FIRST MIDDLE LAST John Simpson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eleanor Lawton				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217 34 0983B		17. INFORMANT Peter C Wells			ADDRESS Riverdale, Md.		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4029 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive-arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Perforated Peptic Ulcer cholelithiasis									
19a. DATE OF OPERATION 2/11/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Perforated Peptic Ulcer				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11 Feb 1980 to 22 Mar 1980 , that (I) (we) lost saw the deceased alive on 22 Mar 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Thomas P Fogarty MD						22c. DATE SIGNED 22 Mar 80		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas P Fogarty	
22e. ADDRESS Langley Park, Maryland									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar 25, 1980		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D C			
24. FUNERAL DIRECTOR NAME F. Gasch's Sons P A						25a. DATE REC'D. BY REGISTRAR MAR 26 1980		25b. REGISTRAR'S SIGNATURE Anthony McCready	
ADDRESS Hyattsville, Md.									

MEDICAL CERTIFICATION

29

6502 BP

WILSON & CO. 1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 0 0 8 0 6 2			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Henry Tyson Wheeler				3 - 6 - 80 0845 PM			
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR 6 24 1911		6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Funeral Director		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Montgomery 13c CITY OR TOWN Bethesda				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e STREET ADDRESS 6550 Democracy Blvd.			
14 FATHER'S NAME FIRST MIDDLE LAST Harry Stanley Wheeler				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Lawrence Wilson			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) WW II 216 07 8723		17 #2022 Center Ct. Gaithersburg, Md. Helen Bowman 10022 Stedwich Rd.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> 496- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe COPD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min. Years.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Myocardial infarction</u>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 3/5/80 to 3/6/80, that (II) (we) lost saw the deceased alive on 3/5/80, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death.							
22b SIGNATURE David Cromwell MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 3/6/80	
22d PHYSICIAN'S NAME (TYPE OR PRINT) David K. Cromwell				22e ADDRESS 831 Univ. Blvd. E. Silver Spring, Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 3/10/80		23c NAME OF CEMETERY OR CREMATORY Darnestown Presby. Church Cemetery		23d LOCATION Darnestown, Md.	
24 FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. NAME ADDRESS 1331 Rockville Pike Rockville, Md. 20852				25a DATE REC'D. BY REGISTRAR MAR 10 1980		25b REGISTRAR'S SIGNATURE [Signature]	

851 Univ. Dr. Silver Spring, Md.

David M. Greenwell

1351 Rockville Pike, Rockville, Md. 20852
Tyson Health Funeral Home, Inc.
3410-80
Bethesda, Md. 20814
Funeral Society of Bethesda, Md.

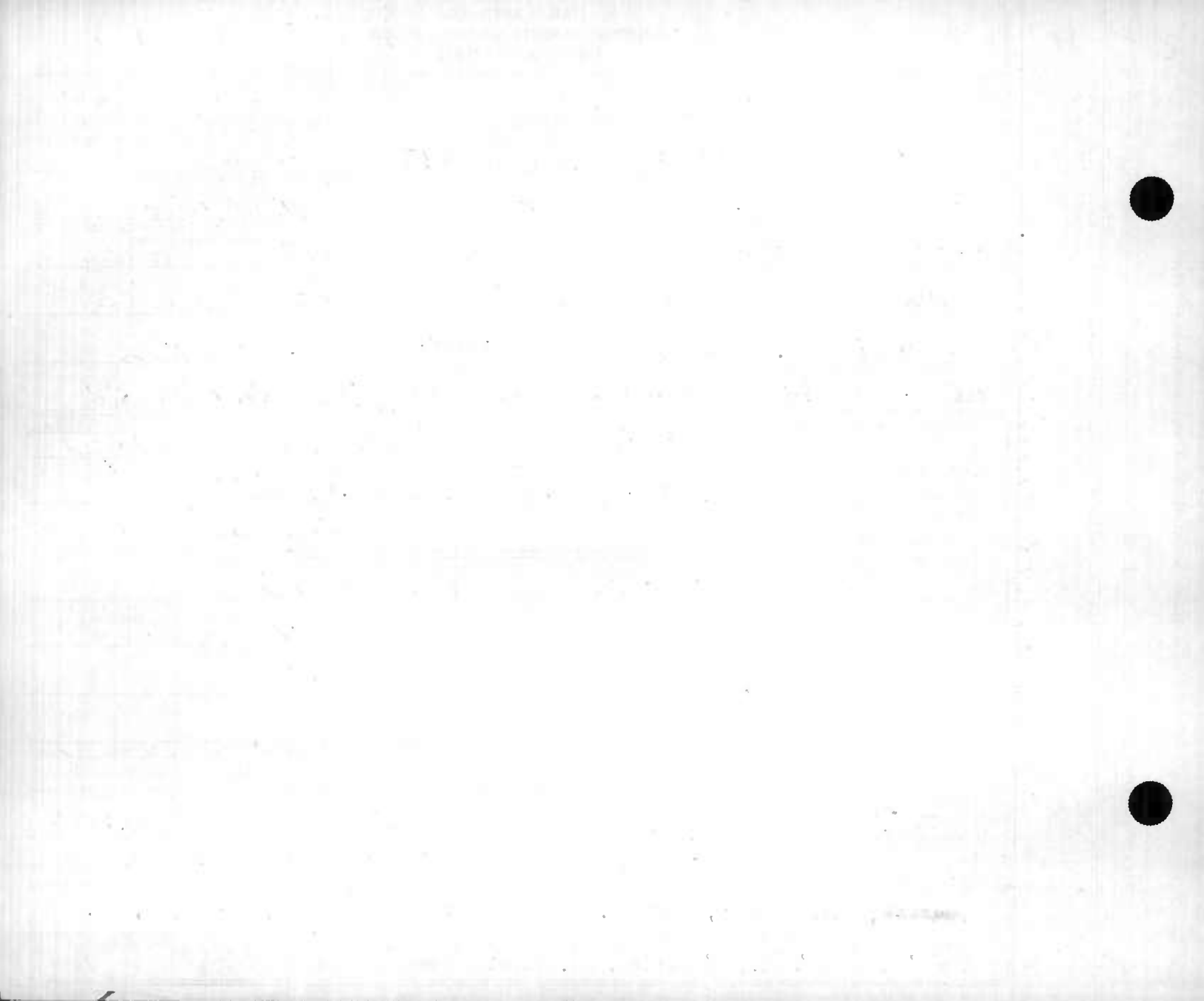
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Geneva Whipp			2a. DATE OF DEATH MONTH DAY YEAR 3 / 26 / 80		2b. HOUR 3 45 pm	
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Aug 12 1897	6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Retail sales	
13a. STATE Md.		13b. COUNTY Mont	13c. CITY OR TOWN Clarksburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Walter S. Reeder		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lottie I. Miss				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) XX No		16b. SOCIAL SECURITY NO. not available		17 INFORMANT ADDRESS Roscoe Whipp (son) Rockville, Md		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 4292 DUE TO, OR AS A CONSEQUENCE OF: (b) Arteriosclerotic cardiovascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF: (c) dissecting APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 10 years						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Chronic congestive heart failure						
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED none		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. None 19 80		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from Feb 4 19 80 , to March 26 19 80 , that (I) (we) lost saw the deceased alive on March 25 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Stephen C. Cromwell, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-26-80
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen C. Cromwell, M.D.		22e. ADDRESS 615 N. Montgomery, Rockville, Md 20850				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar 29, 1980	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Md.	
24. FUNERAL DIRECTOR Richard C. C. C. C. C.		24b. ADDRESS 106 East Church St., Frederick, Md. 21701		25a. DATE REC'D. BY REGISTRAR MAR 31 1980		25b. REGISTRAR'S SIGNATURE John J. C. C. C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR CHARLES EDMOND WHITING									
1. DECEASED NAME (TYPE OR PRINT) CHARLES EDMOND WHITING						2a. DATE OF DEATH MONTH 3 DAY 7 YEAR 1980		2b. HOUR 5:30 P.M.	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH Nov. DAY 2 YEAR 1913		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Editorial		12b. KIND OF BUSINESS OR INDUSTRY Newspaper	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8740 Preston Place	
14. FATHER'S NAME (TYPE OR PRINT) Robert E. Whiting					15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) Jessica Taylor				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 143-07-0649		17. INFORMANT (TYPE OR PRINT) Ruth Whiting ADDRESS see # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure DUE TO, OR AS A CONSEQUENCE OF (b) Complications of the liver DUE TO, OR AS A CONSEQUENCE OF (c) 									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hepatic dysfunction									
19a. DATE OF OPERATION 5-7-80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Hepatic dysfunction				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (CITY OR TOWN COUNTY STATE)					
22a. I certify that (I) (this hospital) attended the deceased from 1975 to 8-7 , 19 80 , that (I) last saw the deceased alive on 3-6 , 19 80 , and that in (my) best opinion death occurred on the date and hour and from the causes stated above, (I) did (did not) view the body after death.									
22b. SIGNATURE (TYPE OR PRINT) Seruch T. Kimble MD				DEGREE MD				22c. DATE SIGNED 3-7-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Seruch T. Kimble, MD				22e. ADDRESS 9801 Georgia Ave., Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Mar. 8, 1980		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (CITY OR TOWN COUNTY STATE) Suitland, PG Maryland			
24. FUNERAL DIRECTOR (NAME ADDRESS) Joseph Gawler's Sons, Washington, D.C.				25a. DATE REC'D. BY REGISTRAR 14 1980		25b. REGISTRAR'S SIGNATURE Ruth Whiting			

MEDICAL CERTIFICATION

U.S. v. [illegible]

1

[illegible]

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[illegible]

[illegible]

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled within 72 hours after death. Page 3 should be filled within 72 hours after death. The medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death. Page 3 should be filled within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR		REG. NO.		7. DATE OF DEATH		MONTH		DAY		YEAR		7b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		3-5-1980		6:10 P.M.			
GRACE		T.		WIGHT									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		8. IF UNDER 1 YEAR		9. IF UNDER 24 HRS			
Female		Caucasian		3/18/19		60		YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Illinois		U.S.A.				Montgomery County, MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Kensington		Kensington Gardens Nursing Home		Homemaker		Home							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Charles		Cobb Island		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		49 N.W. Crain Boulevard					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Alfred		Toennies		Nell		Shore							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS							
No		490-14-6264		Donald E. Wight, same as #13									

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cerebral vascular thrombosis</u>		<u>acute</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral arteriosclerosis</u>		<u>years</u>	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Alzheimer's Disease</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <u>4/25</u> , 19 <u>80</u> , to <u>5 Mar</u> , 19 <u>80</u> , that (2) (we) last saw the deceased alive on <u>28 Feb</u> , 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (3) (we) did / did not view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
<u>John J. Damm</u>				<u>5 Mar 80</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
JOHN J. DAMM		7555 Democracy Blvd Bethesda, Md.					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Cremation		3/5/80		Metropolitan Crematory		Alexandria, Virginia	
24. FUNERAL DIRECTOR		25. DATE FILED BY REGISTRY		26. REGISTRY SIGNATURE			
Robert A. Pumphrey		MAR 11 1980		<u>Robert A. Pumphrey</u>			
7557 Wisconsin Avenue, Bethesda, MD							

100-1-50-10000



100-1-50-10000

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Items 18, 21b-22a G544 6/6/80 STATE OF MARYLAND
 FOR dad DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 1- STATE REGISTRAR MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 08066

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR
OWEN		L.		WILKINSON	3 7 19 80						M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) (LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		24 HOUR
male	white	May 15, 1957		22 YRS.					3 7 19 80		12:25 p M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Montgomery Co. MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Kensington		3914 Kinkaid Terrace				Brick Layer-Macon-Richards					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md.		Mont.		S.S.				15221 Baughman Dr.			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Winston H. Wilkinson				Edna C. Cowell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT Same as ADDRESS above					
None				22070 3060		Winston R. Wilkinson (Father)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Barbiturate Intoxication</u> 9501 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				2 P.M. 3 7 19 80		Subject ingested overdose					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
				Home		3914 Kinkaid Terrace Kensington, Mont., MD.					
22a. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 3-8-80			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Ann M. Dixon, M.D.				111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation				3 /8/80		Lee's Crematory		Wash. D.C.			
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Hines/Rinaldi F.H.				11800 N.H. Ave. S.S. Md.				MAR 12 1980		[Signature]	

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92817



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

08067

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Arthur C. Williams			2a. DATE OF DEATH MONTH DAY YEAR March 14, 1980			2b. HOUR 8:45 A.M.			
3 SEX Male		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR May 30, 1916		6 AGE (IN YEARS LAST BIRTHDAY) 63		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.					13b. CITY OR TOWN Rockville		13c. STREET ADDRESS 611 Lincoln Street		
14. FATHER'S NAME FIRST MIDDLE LAST Frank Williams					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie ?				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Percy Riggs (Brother) 17600 Georgia Ave. Silver Spring, Md.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 3209 DUE TO, OR AS A CONSEQUENCE OF (b) Bacterial meningitis DUE TO, OR AS A CONSEQUENCE OF (c) Chronic emphysema, Chronic Alcoholism Approximate interval between onset and death 5 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic emphysema, Chronic Alcoholism									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR (A.M. OR P.M.) MONTH DAY YEAR 8:45 P.M. 3-14-1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3/14 , 19 80 to 3/14 , 19 80 , that (I) (we) lost saw the deceased alive on 3/13/80 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Kirk Flury MD			DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/14/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kirk Flury, MD					22e. ADDRESS 9410 Old Georgetown Road Bethesda, Md. 20014				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-18-80		23c. NAME OF CEMETERY OR CREMATORY Lincoln Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Montg. Md.		
24. FUNERAL DIRECTOR NAME George R. Snowden					24b. ADDRESS 246 N. Washington Street Rockville, Maryland 20850		25a. DATE REC'D. BY REGISTRAR MAR 19 1980		
					25b. REGISTRAR'S SIGNATURE Anthony McCreedy				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

George A. Hamilton
Hamilton, Kentucky
3-11-40
Lincoln Park
Hamilton, Kentucky

Frank Williams
1300
Nancy Adams (Mother) Silver Spring, Md.
1300
Annie J.

Wichita, Kansas
611 Lincoln Street

U.S.A.
Black

May 30, 1916

cleared by Dr. Ball

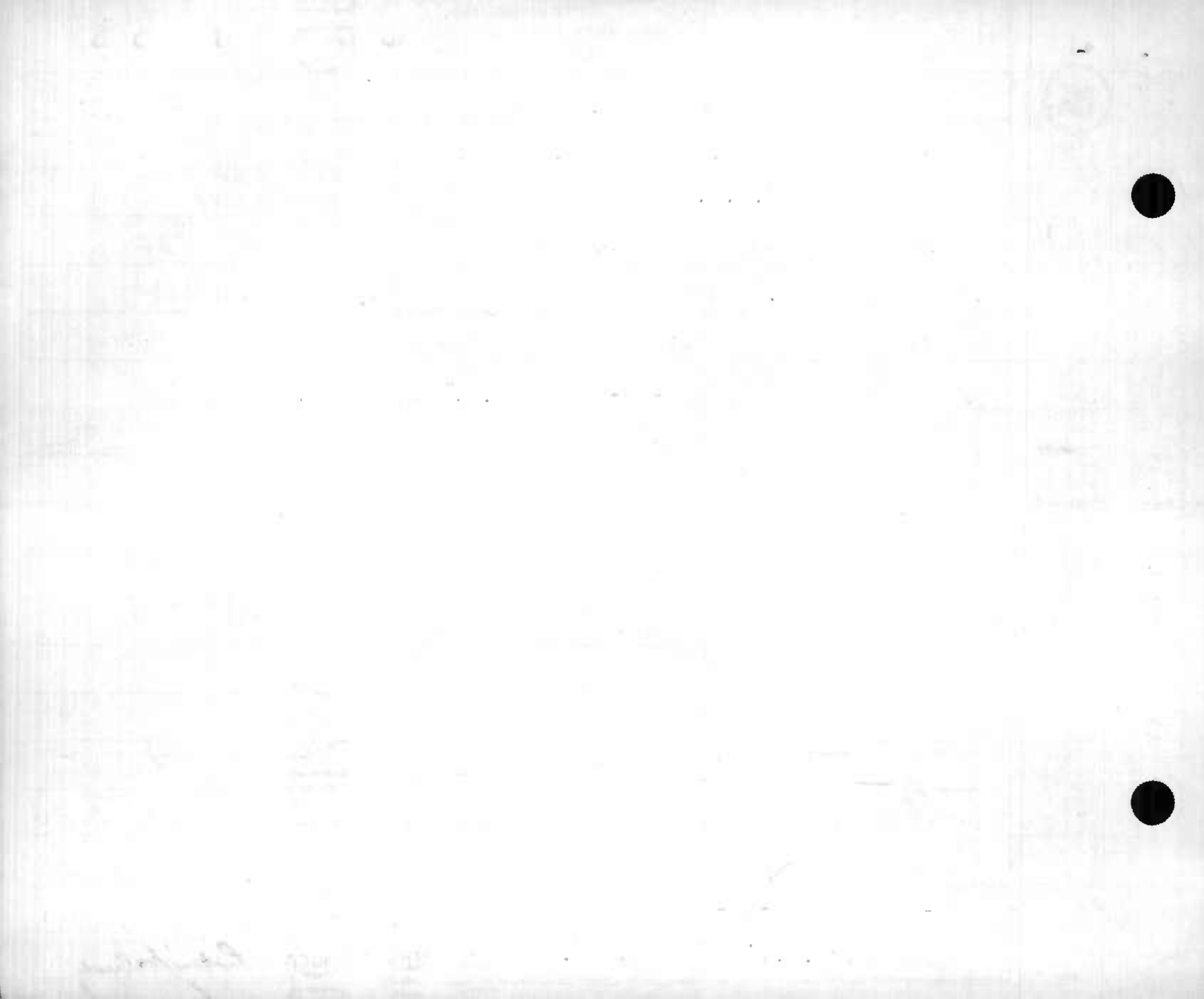
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR			REG. NO. 0008068						
1 DECEASED NAME (TYPE OR PRINT) <i>Dorothy D. Williams</i>			2a DATE OF DEATH MONTH DAY YEAR <i>3-9-80</i>			2b HOUR <i>10¹⁰ P M</i>			
3 SEX <i>Female</i>		4 RACE <i>Cauc.</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>Nov. 23 1894</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>85</i>		7 IF UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>PA</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.			
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hospital</i>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Home</i>		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE <i>Maryland</i> 13c CITY OR TOWN <i>Montg.</i> 13d <i>Bethesda</i>			14 INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		15 STREET ADDRESS <i>8625 Rayburn Road</i>				
14 FATHER'S NAME FIRST MIDDLE LAST <i>Robert Davidson</i>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Martha Murray</i>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b SOCIAL SECURITY NO. <i>481-09-3831</i>		17 INFORMANT ADDRESS <i>D C.T. Williams (Same as 13e)</i>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pneumonia</i> 486- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a DATE OF OPERATION _____		19b CONDITION FOR WHICH OPERATION WAS PERFORMED _____			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <i>19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (the hospital) attended the deceased from <i>several years</i> 19 <i>80</i> , to <i>3-9</i> 19 <i>80</i> , that (I) first last saw the deceased alive on <i>3-9</i> 19 <i>80</i> , and that in (my) my opinion death occurred on the date and hour and from the causes stated above (I) did (did not) view the body after death.									
22b SIGNATURE <i>James W. Egan M.D.</i> DEGREE <i>M.D.</i>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED <i>3.10.80</i>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>JAMES W. EGAN</i>				22e ADDRESS <i>5413 Cedar Lane - Bethesda, Md.</i>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>3-13-80</i>		23c NAME OF CEMETERY OR CREMATORY <i>Memorial Park Cem.</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>Sioux City Iowa</i>			
24 FUNERAL DIRECTOR NAME <i>Robert A. Pumphrey</i> ADDRESS <i>Homes, P.A., Bethesda, Md.</i>				25a DATE REC'D. BY REGISTRAR <i>MAR 19 1980</i>		25b REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR			REG. NO. 008069							
1. DECEASED NAME (TYPE OR PRINT) LOU Jenny WILLIAMS			2a. DATE OF DEATH MONTH DAY YEAR 3-23-80			2b. HOUR 12²⁵ AM				
3. SEX Female		4. RACE White.		5. DATE OF BIRTH MONTH DAY YEAR Sept. 20, 1883		6. AGE (IN YEARS LAST BIRTHDAY) 96		7. UNDER 1 YEAR MONTHS DAYS YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery. MD.				
10. CITY OR TOWN OF DEATH Takoma Park.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sligo Nursing Home. Carroll St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker.		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland.			13b. COUNTY Montg.		13c. CITY OR TOWN Takoma Park.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 722 Erie Ave. Takoma Park.	
14. FATHER'S NAME FIRST MIDDLE LAST Carrington Tucker.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hubbard.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO 215-14-7123		17. INFORMANT 10201 McGovrn Dr. Mavis Dornburg. Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac - Lung Failure. DUE TO, OR AS A CONSEQUENCE OF (b) Aorta Perforation DUE TO, OR AS A CONSEQUENCE OF (c) Gen. Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 day 20 hrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. X 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) X					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) X		21f. LOCATION STREET CITY OR TOWN COUNTY STATE X					
22a. I certify that (1) this hospital attended the deceased from Jan 20, 1980 to March 23, 1980 , that (1) (we) last saw the deceased alive on 2-10-80 and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE R.H. Sandstrom MD					DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-23-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.H. Sandstrom MD					22e. ADDRESS 7741 Carroll Ave Takoma Park, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial.			23b. DATE 3-25-1980		23c. NAME OF CEMETERY OR CREMATORY George Washington		23d. LOCATION CITY OR TOWN COUNTY STATE Riggs Rd. P. Geo. Md.			
24. FUNERAL DIRECTOR NAME Arthur Walker					25a. DATE REC'D. BY REGISTRAR 254 Carroll St N.W. Washington D.C. 20012		25b. REGISTRAR'S SIGNATURE Mary McBrady			

Carlington
 Tacker.
 Hubbard.
 10201 McGovern Dr.
 215-14-7123-avis Cornnura Silver Spring, Md.
 Maryland. Monte. Takoma Park. + 772 Erie Ave. Takoma Park.
 Takoma Park. Slide turning home. Carroll of. Homeowner.
 Virginia. T. S. S.
 Female. White. Sent. 20, 1983.06

Burial. 3-22-1980 George Washington - died 25. P. Geo. 195.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) RICHARD E WILLIAMS				2a. DATE OF DEATH MONTH 3 DAY 31 YEAR 80		2b. HOUR 8:05 AM			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH 7 DAY 1 YEAR 04		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 		8. IF UNDER 24 HRS. HOURS MIN. 	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY NONE			
13a. STATE MD.		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 421 LINCOLN ST.			
14. FATHER'S NAME FIRST FRANK MIDDLE LAST WILLIAMS		15. MOTHER'S MAIDEN NAME FIRST ANNIE MIDDLE LAST HALL									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-228309		17. INFORMANT ADDRESS 9901 MEDICAL CENTER HOSPITAL MEDICAL RECORDS ROCKVILLE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cancer of the esophagus 1509 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE S.J. Withrow M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/31/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S.J. Withrow, M.D.		22e. ADDRESS 15 E. Deer Park, Gaithersburg, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4-3-80		23c. NAME OF CEMETERY OR CREMATORY Lincoln Park Cem.		23d. LOCATION CITY OR TOWN Rockville COUNTY Montg. STATE Md.					
24. FUNERAL DIRECTOR NAME George R. Snowden		ADDRESS 246 N. Wash. St. Rockville Md.		25a. DATE REC'D. BY REGISTRAR APR 7 1980		25b. REGISTRAR'S SIGNATURE Henry M. ...					



Handwritten text, possibly a name or title, located in the upper right section of the page.

ST. LUCAS, M.D.

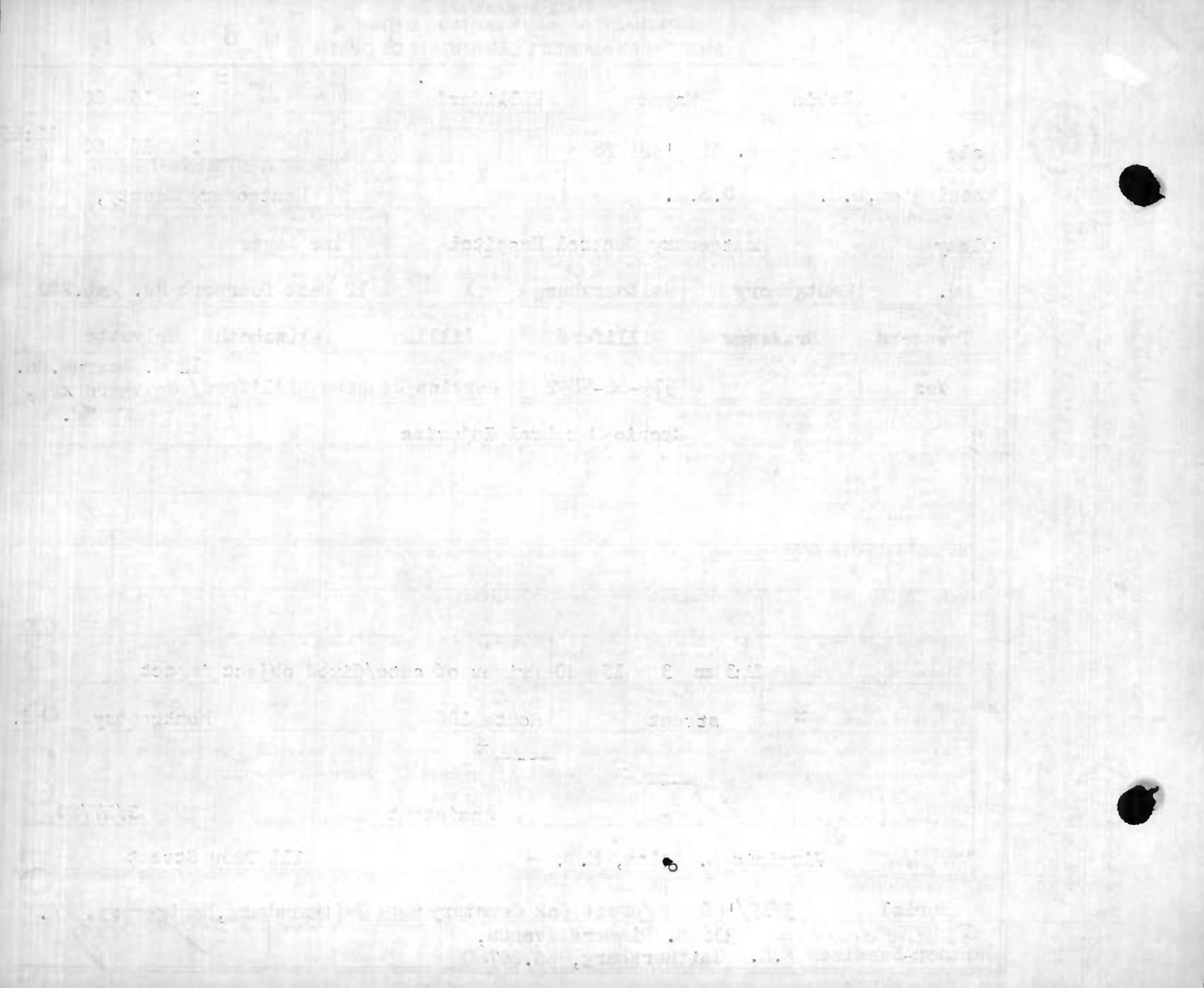
APR 1 1880

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

08071

1. DECEASED NAME (TYPE OR PRINT) Robin Wayne Williford			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 3 16 1980			2b. HOUR M 12:15				
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 29 '52	6. AGE (IN YEARS) LAST BIRTHDAY 28 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 16 1980			2d. HOUR A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10. CITY OR TOWN OF DEATH Olney			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pipe Layer			12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12 West Deerpark Rd. Apt. 202		
14. FATHER'S NAME FIRST MIDDLE LAST Townsend Bradshaw Williford				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Elizabeth Trivette						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 579-66-5892		17. INFORMANT ADDRESS 12 W. Deerpk.Rd. Jessica Johnson Williford/ Gaithersburg,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cranio-Cerebral Injuries 8150 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:30 3 15 1980			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of auto/fixed object impact				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street			21f. LOCATION STREET Route 108		CITY OR TOWN Montgomery		STATE Md.
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE Virginia L. Dolan			TITLE (SPECIFY) Assistant			DATE SIGNED 3/17/80				
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.			ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/19/80		23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery			23d. LOCATION CITY OR TOWN Gaithersburg, Montgomery, Md.		
24. FUNERAL DIRECTOR NAME Gartner-Sandison F.H.			ADDRESS 316 E. Diamond Avenue, Gaithersburg, Md. 20760			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 08072			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ETHEL Elizabeth WILSON				2a. DATE OF DEATH MONTH DAY YEAR 03 15 80			
3 SEX FEMALE				4 RACE White			
5 DATE OF BIRTH MONTH DAY YEAR 08 14 07				6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA				7b. CITIZEN OF WHAT COUNTRY? U.S.A.			
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10 CITY OR TOWN OF DEATH ROCKVILLE				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSP.			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE				12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE MARYLAND				13b. COUNTY MONTGOMERY			
13c. CITY OR TOWN GAITHERSBURG				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET ADDRESS A.B. BOX 187				13f. 16517 Walnut Hill Road			
14. FATHER'S NAME FIRST MIDDLE LAST VICENIOUS LAWRENCE ARUNDEL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE MCGILL Utterback ARUNDEL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO 579485084			
17. INFORMANT ADDRESS MRS. JO THOMSON 16518 WALNUT HILL RD. GAITHERSBURG MD. - 20760							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Hypertensive Cerebrovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Abdominal Pain - Cholelithiasis</u> DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Acute Abdominal Pain - Cholelithiasis</u>							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 14 1980</u> to <u>Mar 15 1980</u> , that (I) (we) <u>did</u> saw the deceased alive on <u>Mar 15 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <u>did</u> (did not) view the body after death.							
22b. SIGNATURE <u>Robert T. Thibadeau</u>				22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT T. THIBADEAU				22e. ADDRESS ROCKVILLE, MD. 20852			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Mar. 19, 1980			
23c. NAME OF CEMETERY OR CREMATORY Union Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Leesburg Loudoun Virginia			
24 FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20760				25. DATE PREPARED BY REGISTRAR MAR 19 1980			
				25b. REGISTRAR'S SIGNATURE <u>Robert T. Thibadeau</u>			



Items 5 and 6 g544 6/13/80 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 008073

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Rached Winfield

2a. DATE OF DEATH MONTH DAY YEAR
3 11 80

2b. HOUR
10³⁰ PM

3. SEX
Female

4. RACE
White

5. DATE OF BIRTH MONTH DAY YEAR
12 19 1885

6. AGE (IN YEARS LAST BIRTHDAY)
84

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Canada

7b. CITIZEN OF WHAT COUNTRY?
U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD

10. CITY OR TOWN OF DEATH
Rockville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Rockville Nursing Home

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher/Artist

12b. KIND OF BUSINESS OR INDUSTRY
Education

13a. STATE
Maryland

13b. COUNTY
Montgomery

13c. CITY OR TOWN
Raithersburg

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS
18901 Smooth Stone Way Apt. 1

14. FATHER'S NAME FIRST MIDDLE LAST
Israel Chiam Weinfeld

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Esther Zweibel

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No

16b. SOCIAL SECURITY NO.
n/a

17. INFORMANT ADDRESS
David Winfield 19204 Seneca Ridge Ct.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) *Cardiac arrest*
5300
DUE TO, OR AS A CONSEQUENCE OF (b) *Malnutrition*
DUE TO, OR AS A CONSEQUENCE OF (c) *achlasia*
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
instantaneous
years
years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
3/17

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
19 80

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from *3/17* 19 *80* to *11 mar* 19 *80* that (I) (we) lost saw the deceased alive on *10 mar* 19 *80* and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE
John Fowcett

22c. DATE SIGNED
3/12/80

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal

23b. DATE
3/12/80

23c. NAME OF CEMETERY OR CREMATORY
George Wash Uni Med School

23d. LOCATION CITY OR TOWN COUNTY STATE
Washington DC

24. FUNERAL DIRECTOR NAME ADDRESS
Metropolitan Funeral Service Alex, Va..

25a. DATE DEC'D. BY REGISTRAR
MAR 18 1980

25b. SIGNATURE
John Fowcett

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Remainder
U.S.A.
Wichita
Locustville
Maryland

Target
Chin
Refined
Number
Davidson

Davidson
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Number

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[illegible]

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP _____
DHMH - 17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND									
DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
REG. NO. 08074									
1. DECEASED NAME (TYPE OR PRINT) George Clarence Witherspoon									
2a. DATE KNOWN OF DEATH 12 MONTH DAY YEAR 25 8 1980									
3. SEX M 4. RACE B 5. DATE OF BIRTH 1 33 48 6. AGE (IN YEARS LAST BIRTHDAY) 7. IF UNDER 1 YR. 8. IF UNDER 24 HRS. 9. DATE PRONOUNCED DEAD March 10 1980									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) So. Carolina 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED X NEVER MARRIED WIDOWED DIVORCED 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD									
10. CITY OR TOWN OF DEATH Tak Park Wash. 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Vincent Hosp. 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver 12b. KIND OF BUSINESS OR INDUSTRY John Briggs Co.									
13a. STATE Md 13b. COUNTY Prince George's 13c. CITY OR TOWN Hyattsville 13d. INSIDE CITY LIMITS? YES X NO 13e. STREET ADDRESS 500 Chillum Rd.									
14. FATHER'S NAME Johnson 15. MOTHER'S MAIDEN NAME Queen 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 17. SOCIAL SECURITY NO. 251-50-5677 18. INFORMANT ADDRESS 500 Chillum Rd., 19. WILLIE BEA WITHERSPOON-HYATTSVILLE, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1 DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Acute Myocardial Dis.									
DUE TO, OR AS A CONSEQUENCE OF									
(b) Chronic Myocardial Dis.									
DUE TO, OR AS A CONSEQUENCE OF									
(c) Chronic Obstructive Pulmonary Dis. Xrs									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
None									
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES NO X									
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes X Accident Suicide Homicide Undetermined manner									
ACTUAL SIGNATURE John S. Rogers M.D. TITLE (SPECIFY) M.D. MEDICAL EXAMINER DATE SIGNED March 10 1980									
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers ADDRESS 1919 Seminary Rd., Silver Spring, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE Mar. 13, 1980 23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE Hartsville So. Car.									
24. FUNERAL DIRECTOR NAME ADDRESS Hines/Rinaldi F.H.-11800 NH Ave. Sil. Spr., Md. 25a. DATE REC'D. BY REGISTRAR MAR 13 1980 25b. REGISTRAR'S SIGNATURE Hines/Rinaldi									

George

Oliver

Richardson

So. Carolina

2-4

John Weaver

James

James

Richardson

Johnson

John

No

251-50-5011, Willie Ann Richardson - Greenville, SC

John E. Rogers

Greenville

12-13, 1980 Greenville County

North

1980

Greenville and E. E. - 1980 Greenville County

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 0 0 8 0 7 5									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Gladys		V		Wolford.				March 5, 1980		4:25 p.m.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
Female		White		July 14, 1905		74 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Montgomery MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									
Silver Springs		Fairland Nursing Home									
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Housewife											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
Maryland		P.G. Co.		Beltsville		13e. STREET ADDRESS					
						11926 Beltsville Dr. Apt. 5					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Robert F. Shives		Ella Vance									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No.		None		Ernest N. Wolford		same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ventricular Arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4149										3 min	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										5 yrs	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Parkinsonism</u>										10 yrs	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>May 3</u> 19 <u>78</u> , to <u>March 5</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>Feb 6</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
<u>James R. Moore Jr.</u>		MD		3-5-80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
James R. Moore Jr.		207 Brookes Ave Gaithersburg Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		3/7/80		Cedar Lawn Mem. Park		Hagerstown Wash. Co. Md.					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE									
FLECK LAUREL FUNERAL HOME, INC.		MAR 7 1980 <u>Fleck</u>									
7601 Sandy Spring Rd. Laurel, Md. 20810											

March 2, 1900

Went out to the
field to see the
crops.

For the
first time
the crops are
growing well.

MAR 7 1900

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frederick W. Woodley, Sr.										2a. DATE OF DEATH MONTH DAY YEAR 3 27 80		2b. HOUR 12 35 P.M.	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 6 3 78		6. AGE (IN YEARS LAST BIRTHDAY) 101 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 2 YRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Conn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.							
10. CITY OR TOWN OF DEATH Takoma Park, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED.		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Va.		13b. COUNTY Fairfax		13c. CITY OR TOWN Annandale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3801 WINTERSET Dr Annandale, Va.					
14. FATHER'S NAME FIRST MIDDLE LAST Frederick W. Woodley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Turgenson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None				16b. SOCIAL SECURITY NO. 578 07 8197		17. INFORMANT Same as above Frederick Woodley, Jr. (Son)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute respiratory failure 4870 DUE TO, OR AS A CONSEQUENCE OF (b) bilateral bronchopneumonia 8 days (c) possible, unconfirmed influenza PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) severe hypovolemic shock 2° dehydration										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HRS.			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22. I certify that (1) (this hospital) attended the deceased from 3/21 19 80, to 3/27 19 80, that (1) (we) last saw the deceased alive on 3/27 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.													
22a. SIGNATURE Randell P. Gura, M.D.						DEGREE M.D.		22c. DATE SIGNED 3-27-80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RANDELL P. GURA, M.D.						22e. ADDRESS Washington Adventist Hosp.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/31/80		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.							
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.11800						ADDRESS N.H.Ave.s.s.Md.		25. REGISTRAR'S SIGNATURE MAR 31 1980					



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MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
Rose C Wright				March 6, 1980				3:00 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		7. IF UNDER 24 HRS	
Female		Caucasian		Aug. 31 1900		79 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Montgomery MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Carriage Hill Nursing Home				Nurse (Ret)		Nursing			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13. STREET ADDRESS	
D.C.						Washington		YES <input type="checkbox"/> NO <input type="checkbox"/>		2701 Conn Ave., N.W.	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Peter Edward Wright				Sara Ella Dailey Banley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				212-22-9117 A		Mary E Shumate, 3912 Virginia St. Chevy Chase, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u>										10 months	
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Multiple Bone Metastases</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR							
				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK						STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> , 19 <u>79</u> , to <u>March 6</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>3/1</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE								DEGREE		22c. DATE SIGNED	
David B. Simon, M.D.										March 6, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)								22e. ADDRESS			
David B. Simon								Suite 420 916-19th St. NW Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial				3/10/1980		St. Patricks Cemetery		Cumberland, Maryland.			
24. FUNERAL DIRECTOR								25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.								MAR 14 1980		[Signature]	

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			2b. HOUR
MAX			YAVENER			MARCH 8, 1980			8:05 P.M.
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		APRIL 25, 1895		84		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Connecticut		U. S. A.				Montgomery MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Wheaton		UNIVERSITY NURSING HOME				Merchant		Grocery	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d INSIDE CITY LIMITS?		13e STREET ADDRESS		
13a STATE 13b COUNTY 13c CITY OR TOWN					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1121 Univ. Blvd. West, #1115		
14 FATHER'S NAME					15 MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST					FIRST MIDDLE LAST				
Barnett Yavener					Rebecca Shapiro				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS		
No			145-01-3968		Ann Yavener		Same as No. 13		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio-pulm - failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>carcinoma of rt lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>1629</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1979</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (this hospital) attended the deceased from <u>1-14</u> , 19 <u>80</u> , to <u>2-28</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>2-28</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b SIGNATURE						DEGREE		22c. DATE SIGNED	
Frauke Westphal M.D.						MD for ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		3-9-1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e ADDRESS				
Frauke Westphal, M. D.					809 Viers Mill Road, Rockville, Maryland				
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		3/11/1980		King David Memorial Garden		Falls Church, Virginia			
24 FUNERAL DIRECTOR NAME					24b. DATE OF RECORD BY REGISTRAR				
Donald M. Stein Hebrew Memorial F.H.					MAR 13 1980				
232 Carroll Street, N. W. Washington, D. C.									

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 0 8 0 7 9

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bessie G Yocum			2a. DATE OF DEATH MONTH 3 DAY 2 YEAR 80			2b. HOUR 1:25 ^A					
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH 6 DAY 1 YEAR 08		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 		8. IF UNDER 74 HRS. HOURS MIN 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Montg. 13c. CITY OR TOWN Rockville						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 723 Maple Avenue			
14. FATHER'S NAME FIRST Charles MIDDLE LAST Lyons						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not available					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 482/09/8059		17. INFORMANT ADDRESS Paul S. Yocum same as 13e					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 436- DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cerebrovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Warfarin therapy may have contributed.												
19a. DATE OF OPERATION 			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:30 P.M. 3 1 1980			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Cerebrovascular accident						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home.			21f. LOCATION STREET 723 Maple Ave CITY OR TOWN Rockville COUNTY Montg. STATE MD.						
22. I certify that (I) (this hospital) attended the deceased from 8:30 PM 3/1 1980 to 1:25 AM 3/2 1980 , that (I) (we) last saw the deceased alive on 1/30/80 3/1 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												
23a. SIGNATURE Thomas G. Harvey M.D.						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		23b. DATE SIGNED 3/2/80		
24a. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas G. Harvey M.D.						24b. ADDRESS 50 W. Edmonston Dr. Rockville, Md 20852						
25a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			25b. DATE 3/5/1980		25c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park			25d. LOCATION CITY OR TOWN Rockville COUNTY Montg. STATE Md.				
26. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A.						26b. ADDRESS Rockville, Md.		26c. DATE MAR 10 1980		26d. REGISTRAR Robert A. Pumphrey		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR						2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		TING GUEY YUEN						3 5 80 645 ^a M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		Chinese		July 14, 1900		79		MONTHS DAYS HOURS MIN	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Canton, China		U.S.A.				MONTGOMERY MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA		Suburban Hospital				Ret. Laundry Operator			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.		Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5408 Bradley Blvd.	
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
Leong Don Yuen				Lee Ling Shee					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS			
No				None		20832 Kenneth Yuen-son 3836 Wilberta St. Olney, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492- Ventricular Tachycardia DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary emphysema and fibrosis DUE TO, OR AS A CONSEQUENCE OF (c) Renal failure								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 15 years 3 MONTHS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) CONGESTIVE HEART FAILURE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1970 to MARCH 5 1980, that (I) (we) (we) saw the deceased alive on MARCH 4 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death.									
22b. SIGNATURE Edward W. Youngblood, M.D.				DEGREE M.D.				22c. DATE SIGNED MARCH 5, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD W. YOUNGBLOOD				22e. ADDRESS 4900 MASS. AVE, N.W. WASHINGTON D.C.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		3-8-1980		Ft. Lincoln Cemetery		Golfmor Manor, Md.			
24 FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE FILED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Lee Funeral Home				300-4th St. N.E. Wash. D.C. 20002		MARCH 10 1980		[Signature]	

[illegible]

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

0 8 0 8 1

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ALFRED CARL ZANDER			2a. DATE OF DEATH MONTH 3 DAY 2 YEAR 80			2b. HOUR 10:19p	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH Feb. DAY 9 YEAR 1909		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) US Gov't	
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Fred MIDDLE Zander LAST Zander		15. MOTHER'S MAIDEN NAME FIRST Clara MIDDLE Mewis LAST Mewis		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WWII			
16b. SOCIAL SECURITY NO. 493 10 0081		17. INFORMANT'S NAME AND ADDRESS Same as above Helen B. Zander (Wife)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Bilateral Pulmonary Emboli DUE TO, OR AS A CONSEQUENCE OF (b) s/p Abdominal resection of DUE TO, OR AS A CONSEQUENCE OF (c) Massive retroperitoneal liposarcoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH few hours 2 days 5 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH 19 DAY 19 YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from May 18, 1977 to March 2, 1980 , that (I) (we) last saw the deceased alive on March 2, 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. Minarcik				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/3/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Minarcik, MD				22e. ADDRESS 18101 Pr. Philip Dr. Olney, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/6/80		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood COUNTY Mont. STATE Md.	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H.11800 ADDRESS N.H.Ave.S.S.Md.				25a. DATE REC'D. BY REGISTRAR MAR 6 1980		25b. REGISTRAR'S SIGNATURE Ritony McCreedy	

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MEDICAL CERTIFICATION

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO. 3 0 0 8 0 8 2			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) JOSEPH (F.) -ZAUNER, (JR.)				2a. DATE OF DEATH MONTH DAY YEAR 3-28-80		2b. HOUR 11:35 P M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Apr. 18. 1900		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Mgr.		12b. KIND OF BUSINESS OR INDUSTRY Medical Equip	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Zauner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie M. Eichler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 061-05-5964		17. INFORMANT ADDRESS Joseph F. Zauner, Jr. Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 1991 HYPOSTATIC PNEUMONIA						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (b) INANITION + DEHYDRATION						1 WEEK	
DUE TO, OR AS A CONSEQUENCE OF (c) BASAL CELL CARCINOMA, METASTATIC						3 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cerebral arteriosclerosis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from NOV. 19 78 to MARCH 80 , that (I) (we) last saw the deceased alive on MARCH 26 19 80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, (we) (I) did not view the body after death.)							
22b. SIGNATURE Joseph Connor				DEGREE M.D.		22c. DATE SIGNED MARCH 29, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Connor, M.D.				22e. ADDRESS Bethesda, Md. 9420 Old Georgetown Rd.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 31, 1980		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Md.	
24. FUNERAL DIRECTOR NAME Robert A. Humphrey				25. DECEASED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 2 1980			
Homes, P.A. Bethesda, Md.							

APR 14 1970

WOMEN

Rockville Collins and Nursing Home

2007 Lancaster Ave.

Joseph

Thurman

Paris

101-05-2804 Joseph T. Thurman, Jr. Case # 17

WOMEN + THURMAN +
INMATE - DEPORTATION 1 WEEK
CARRINGTON + 1970 + 1971

Substantive

APR 14 1970

RECEIVED

Joseph T. Thurman, Jr.

APR 14 1970

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Joseph				ZINICH	March	18	1980	1215P	M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male	Caucasian	June 15 1926		53	MONTHS DAYS		HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Michigan	USA			Montgomery MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda	National Naval Medical Center			U. S. Navy		Marine Corp Exchange			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS				
Virginia		Prince Wm.	Quantico	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	403-Broadway				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
Matthew Frank Zinich		(Unobtainable)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Yes		1943-63		580 22 8689		Mr. Albert Hornik, Norwalk St. Hamtromck/ Michigan			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 1509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Esophageal Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I (this hospital) attended the deceased from <u>March 3</u> 19 <u>80</u> , to <u>March 18</u> 19 <u>80</u> , that (I (we) lost saw the deceased alive on <u>March 18</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED		
Chris K. Finton							March 19, 1980		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Chris K. Finton, M.D.		National Naval Medical Center, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE
Burial		Mar. 24, 1980	Arlington National		Arlington		Arlington		Va.
24. FUNERAL DIRECTOR'S NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Cunningham Mountcastle		MAR 20 1980		[Signature]					

NAPT 03 244